DOCUMENT RESUME

ED 023 211 EC 002 561

By-Cowen, Emory L., Ed.; And Others

Emergent Approaches to Mental Health Problems. The Century Psychology Series.

Pub Date 67

Note-479p.; Impetus for the publication largely from conference on "Emergent Approaches to Mental Health Problems" (June 17-19, 1965).

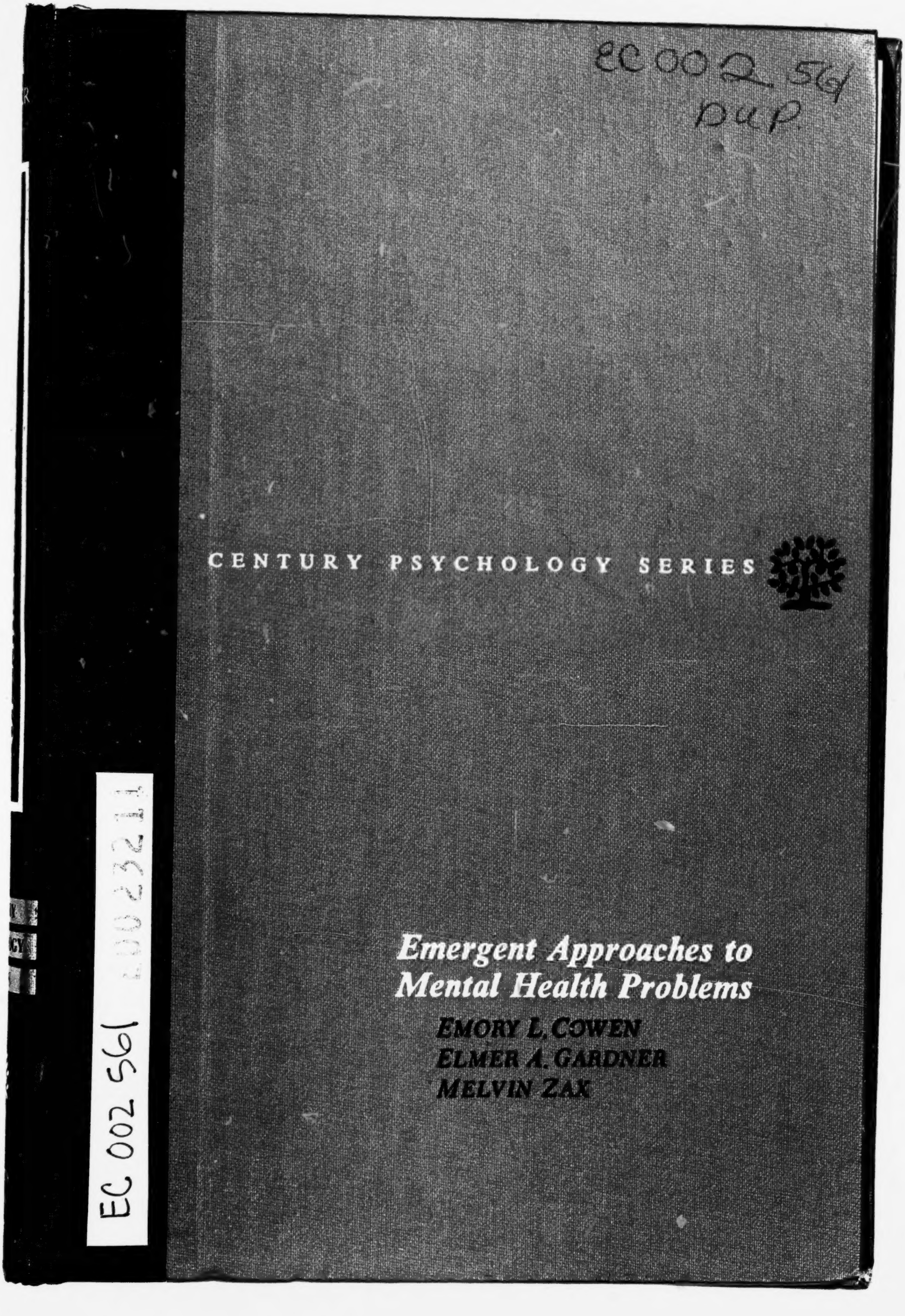
Available from-Appleton-Century-Crofts, 440 Park Avenue South, New York, New York 10016 ($9.00).

EDRS Price MF-$2.00 HC Not Available from EDRS.

Descriptors-Behavior Theories, *Community Programs, Counselor Training, Culturally Disadvantaged, Educational Therapy, *Emotionally Disturbed, *Exceptional Child Education, Manpower Development, Manpower Utilization, Mental Health Programs, *Personnel, Prevention, Project Training Methods, Psychoeducational Processes, *Psychotherapy, School Community Programs

Innovative approaches to mental health problems are described. Conceptualizations about the following areas are outlined: psychiatry, the universe, and the community; theoretical malaise and community mental health; the relation of conceptual models to manpower needs; and mental health manpower and institutional change. Community programs and new sources of manpower are considered in terms of college students as companions to the mentally ill, pilot training projects for mental health counselors, new manpower for mental hospital service, training of human service aides, a neighborhood based mental health approach, psychological care for the poor, and a small community's mental health consultation program. New approaches in the schools include preventive aspects of school experience, prevention in the classroom through a behavioral sciences teaching program, enhancing a teacher's mental health function, history and evaluation of the St. Louis School Mental Health Project, a project's strategies in mental health consultation, early identification and prevention of emotional disturbance in a public school, project Re-ED (educational intervention in discordant child rearing systems), and a school district's program for schizophrenic, organic, and seriously disturbed children. Directions are indicated for future work. A bibliography cites 167 items. (SN)

EC 002 561
DUP.



CENTURY PSYCHOLOGY SERIES

Emergent Approaches to Mental Health Problems

EMORY L. COWEN
ELMER A. GARDNER
MELVIN ZAX

EC 002 561
ED 023211

EC002561

ED023211

EMERGENT APPROACHES TO MENTAL HEALTH PROBLEMS

EC 002 561

"PERMISSION TO REPRODUCE THIS COPYRIGHTED
MATERIAL BY MICROFICHE ONLY HAS BEEN GRANTED
BY BURTON C. FRYE, APPLETON-CENTURY-CROFTS
TO ERIC AND ORGANIZATIONS OPERATING UNDER
AGREEMENTS WITH THE U. S. OFFICE OF EDUCATION.
FURTHER REPRODUCTION OUTSIDE THE ERIC SYSTEM
REQUIRES PERMISSION OF THE COPYRIGHT OWNER."

The Century Psychology Series

Richard M. Elliott
Gardner Lindzey
Kenneth MacCorquodale

editors

EMERGENT APPROACHES TO MENTAL HEALTH PROBLEMS

Emory L. Cowen, Ph.D.
University of Rochester

Elmer A. Gardner, M.D.
Temple University

Melvin Zax, Ph.D.
University of Rochester

New York

Appleton-Century-Crofts
Division of Meredith Publishing Company

Copyright © 1967 by
MEREDITH PUBLISHING COMPANY

All rights reserved.

This book, or parts thereof, must not be used or reproduced in any manner without written permission. For information address the publisher, Appleton-Century-Crofts, Division of Meredith Publishing Company, 440 Park Avenue South, New York, N. Y. 10016.

697-1

Library of Congress Card Number: 67-26274

PRINTED IN THE UNITED STATES OF AMERICA

E 21335

FOREWORD

This volume has drawn together the descriptions of several emerging, innovative approaches to mental health problems. It stems from an Institute held at the University of Rochester in June, 1965, and reaches publication at a particularly advantageous time. With the passage of the staffing grant act (Public Law 89-105) the community mental health center program is nearing fruition and, though stimulating considerable expansion of mental health services, brings into focus a number of problems requiring resolution. The development of mental health centers throughout the nation emphasizes the need for increased manpower, better coordination of health and social services, a greater involvement of all the community caretakers in the promotion of mental health, more flexibility and experimentation in the delivery of services and, wherever possible, a shift from therapeutic to preventive intervention.

We need to reexamine the assumptions and models that have guided our mental health programs, and to search for new methods in the distribution of our manpower. In the past those who most required help too frequently found it least available. The approaches described in this book represent attempts to correct such inadequacies and to reconceptualize existing models. Though still in an evolutionary stage, the programs described here are important because they constitute clear-cut illustrations of emergent and changing practice in the mental health sphere and stand as operating models. It is recognized that mental health problems cannot be the exclusive responsibility of any single discipline.

Conceptually, the volume emphasizes a preventive approach and the development of theory to underline the promotion of mental health. If the community mental health centers are to be truly innovative, they will need the background of knowledge and experience presented in this book.

The authors are eminently qualified by experience and training to discuss the emergent approaches to mental health. The mental health program in Rochester has long been known as a dynamic and innovative one, which has been not only home territory, but classroom and laboratory to Doctors Cowen, Gardner, and Zax. Like their colleagues elsewhere, I have followed with great interest the developments in Rochester and Monroe County. My visits there have added to my enthusiasm. This book which stems from the work there will fill a real need for mental health workers.

R. H. Felix, M.D., M.P.H.

PREFACE

The mental health problems of modern society are complex and deeply rooted. Only relatively recently in the history of man has the significance of such problems been clearly recognized. Since then we have been engaged in a growing struggle to reduce the human inefficiency and to combat the human misery that derive from emotional difficulties. This effort, necessarily, has been guided by pragmatic considerations and immediate, felt pressures for help. The present volume considers the effectiveness of the traditional and historically dominant approaches that have evolved as part of the early, systematized efforts of society to deal with disordered function. On this basis, it seeks to delineate fundamental issues that must be engaged if we are to achieve a sounder mental health order in the future. An attempt is made to articulate alternative conceptual models, including the types of programs and research which stem logically from these.

The largest single portion of the volume, however, consists of a series of concrete descriptions of innovative and viable "programs-in-action" addressed to specific aspects of our total mental health problem. Included among these are community mental health programs, special mental programs for the poor, programs for training new, nonprofessional, mental health manpower, and primary, as well as early secondary, preventive programs in the schools. The approach to the volume is nonparochial. The issues addressed are ones of general relevance to all members of the helping professions. Contributing authors include educators, psychiatrists, psychologists, and sociologists.

Considerable impetus for this volume came from a conference on "Emergent Approaches to Mental Health Problems" (June 17-19, 1965) jointly sponsored by the Department of Psychology and Psychiatry at the University of Rochester. The conference consisted of a series of half-day sessions, each of which dealt with a topic of central relevance to the larger area. The opening meeting on "New Approaches in Mental Health Manpower" was chaired by Kenneth E. Clark, Ph.D., and it included an introduction overview talk by John Romano, M.D., invited addresses by Robert Reiff, Ph.D. and Richard Sanders, Ph.D., and discussion by George W. Albee, Ph.D. and Milton Greenblatt, M.D. The second session on "Primary Prevention in the Community," chaired by Harold C. Miles, M.D., included formal talks by Fred Duhl, M.D. and Frank Riessman, Ph.D., discussed by John Cumming, M.D. and Sheldon R. Roen, Ph.D. A third session dealing with "Early Secondary Prevention" was chaired by Robert Haggerty, M.D. and included invited presentations by Wilbert W. Lewis, Ed.D. and George T. Donahue, Ed.D., with discussion by Sidney Koret, Ph.D. and Eli M. Bower, Ed.D. A fourth session led by William Fullagar, Ed.D. was directed to the topic of "Preventive Approaches in the Schools" and included formal presentations by Ira Iscoe, Ph.D. and Margaret C.-L. Gildea, M.D. as discussed by Herbert Zimiles, Ph.D. and William C. Morse, Ph.D. A final plenary session consisted of free discussion, by all conference participants, with respect to the substance of the prior meetings and related materials. This session was chaired by S. D. Shirley Spragg, Ph.D. and moderated by Robert Berg, M.D.

The conference described above was arranged by a coordinating committee including the three editors and Norman I. Harway, Ph.D., Head, Division of Psychology, Department of Psychiatry, University of Rochester School of Medicine. The editors wish to express their sincerest appreciation to Dr. Harway for his important contributions to this effort. Support for the conference came from several sources including the following: MH 5146-18, Training Program in Clinical Psychology; MH 8469-02, Graduate Training in Community Psychiatry; MH 1500-01, Early Detection and Prevention of Emotional Disorders—each of the foregoing from the National Institute of Mental Health. Additional support was provided from the General Funds of the Department of Psychiatry and from the Department of Psychology at the University of Rochester. We are most grateful to each of these sources for their help. It should also be noted that some of the thinking that goes into the volume, particularly the first and last chapters, may be traced back to the conference and, in that sense, the authors owe a debt of gratitude to all of the participants.

The conduct of the conference itself was greatly facilitated by the generous participation of David Beach and James D. Laird, who assisted both with arrangements and recording, and by the important secretarial and clerical contributions of Miss Jane Ellickson, Mrs. Carol Hunt, and Mrs. Pattie Spencer. Preparation of the manuscript was effectively handled by Miss Jane Ellickson, Mrs. Thelma Levin, Mrs. Alice McKay, and by Mrs. Marcia R. Macklin, who typed the final draft. Mr. Julian Rappaport contributed meaningfully to the early editing of the individual chapters, as did Mr. G. Ramsay Liem and Mr. Richard J. Cowen during the latter phases of the editorial cycle. We are deeply indebted to the foregoing individuals and are most appreciative of their significant contributions to the final product.

E. L. C.
E. A. G.
M. Z.

CONTRIBUTORS

George W. Albee, Ph.D., Professor of Psychology and Clinical Psychology Program Chairman, Department of Psychology, Western Reserve University, Cleveland, Ohio.

Emory L. Cowen, Ph.D., Professor of Psychology, Associate Chairman and Director of Clinical Training, Department of Psychology, University of Rochester, and Associate in Psychiatry (Psychology), University of Rochester School of Medicine, Rochester, New York.

John Cumming, M.D., Deputy Commissioner for Mental Health, New York State Department of Mental Hygiene, Albany, New York.

George T. Donahue, Ed.D., Director of Professional Services, Jewish Vocational Service, Milwaukee, Wisconsin; formerly Assistant Superintendent of Schools, New Rochelle, New York, and Elmont, New York.

S. Thomas Friedman, Ph.D., Assistant Professor of Educational Psychology, Department of Educational Psychology, The University of Texas; Research Director, Personnel Services Research Center, The University of Texas, Austin, Texas.

Elmer A. Gardner, M.D., Associate Professor of Psychiatry, Director, Community Mental Health Center and Division of Social Psychiatry, Department of Psychiatry, Temple University Health Sciences Center, Philadelphia, Pennsylvania.

Margaret C.-L. Gildea, M.D., Associate Clinical Professor of Psychiatry, Washington University School of Medicine, St. Louis, Missouri.

John C. Glidewell, Ph.D., Associate Professor of Education and Sociology, Washington University, and Director of Research and Development, St. Louis County Health Department, St. Louis, Missouri.

Jules D. Holzberg, Ph.D., Director of Research, Connecticut Valley Hospital; Professor of Psychology, Wesleyan University, Middletown, Connecticut.

Ira Iscoe, Ph.D., Professor of Psychology and Education, Department of Psychology, The University of Texas; Associate Director, Personnel Services Research Center; Director, Graduate Training in Community Mental Health, The University of Texas, Austin, Texas.

Mildred B. Kantor, Ph.D., Assistant Professor of Sociology and Associate Director of a Training Program in Mental Health Research of the Social Science Institute of Washington University, and Director of Vital Statistics of the St. Louis County Health Department, St. Louis, Missouri.

William L. Klein, Ph.D., Assistant Director for Training, Institute for Youth Studies, Howard University and Assistant Professor of Psychiatry, Howard University Medical School, Washington, D.C. (on leave); Lecturer, Department of Psychology, Hebrew University, Jerusalem, Israel, and Supervising Psychologist, National Institute for Counseling and Guidance, Israel.

Robert H. Knapp, Ph.D., Professor of Psychology, Wesleyan University, Middletown, Connecticut.

Wilbert W. Lewis, Ed.D., Associate Professor of Psychology, Director of Research and Training, Project Re-ED, and Director of Research Group on Children with Behavior Disorders, George Peabody College for Teachers, Nashville, Tennessee.

Loyce D. McGehearty, Ph.D., Director of Guidance, The University of Corpus Christi, Corpus Christi, Texas; formerly Demonstration Center Coordinator, Personnel Services Research Center, The University of Texas, Austin, Texas.

William C. Morse, Ph.D., Professor of Educational Psychology and Psychology; Chairman of the Combined Program in Education and Psychology, The University of Michigan, Ann Arbor, Michigan.

John Pierce-Jones, Ph.D., Professor of Educational Psychology, Department of Educational Psychology, The University of Texas, and Director, Personnel Services Research Center and Director, Southwest Child Development Evaluation and Research Center, The University of Texas, Austin, Texas.

Robert Reiff, Ph.D., Associate Professor and Director, Division of Psychology, and the Center for the Study of Social Intervention, Albert Einstein College of Medicine, New York, New York.

Frank Riessman, Ph.D., Professor of Educational Sociology, New York University, New York, New York; formerly Associate Professor, Department of Psychiatry, Albert Einstein College of Medicine and Director, Mental Health Aide Program of Lincoln Hospital Mental Health Services, New York, New York.

Margaret J. Rioch, Ph.D., Clinical Psychologist; Member of Executive Council and Chairman of Group Relations Conference Committee, Washington School of Psychiatry, Washington, D.C.

Sheldon R. Roen, Ph.D., Associate Professor of Psychology and Education, Department of Psychology; Director, Psychological Consultation Center, Teachers College, Columbia University, New York, New York; formerly Director of Research, South Shore Mental Health Center, Quincy, Massachusetts.

John Romano, M.D., Professor and Chairman, Department of Psychiatry, University of Rochester School of Medicine and Dentistry; Psychiatrist-In-Chief, Strong Memorial Hospital, Rochester, New York.

Richard Sanders, Ph.D., Director of Psychological Services, Philadelphia State Hospital, Philadelphia, Pennsylvania.

Charles D. Spielberger, Ph.D., Professor of Psychology, Florida State University, Tallahassee, Florida; formerly Professor of Psychology, Vanderbilt University, Nashville, Tennessee.

John leB. Turner, Ph.D., Senior Research Psychologist, Connecticut Valley Hospital; Research Associate in Psychology, Wesleyan University, Middletown, Connecticut.

R. Jay Turner, Ph.D., Senior Research Scientist, New York State Department of Mental Hygiene, Mental Health Research Unit, Syracuse, New York.

Melvin Zax, Ph.D., Professor of Psychology and Associate Director of Clinical Training, Department of Psychology, University of Rochester, and Associate in Psychiatry (Psychology), University of Rochester School of Medicine, Rochester, New York.

Herbert Zimiles, Ph.D., Chairman, Research Division, Bank Street College of Education, New York, New York.

CONTENTS

Foreword v

Preface vii

Contributors ix

I. INTRODUCTION

1. The Mental Health Fields Today: Issues and Problems
Emory L. Cowen and Melvin Zax 3

II. CONCEPTUALIZATIONS

2. Psychiatry, the University, and the Community
John Romano 33

3. Theoretical Malaise and Community Mental Health
R. Jay Turner and John Cumming 40

4. The Relation of Conceptual Models to Manpower Needs
George W. Albee 63

5. Mental Health Manpower and Institutional Change
Robert Reiff 74

III. COMMUNITY PROGRAMS AND NEW SOURCES OF MANPOWER

6. College Students as Companions to the Mentally Ill
Jules D. Holzberg, Robert H. Knapp, and John L. Turner 91

7. Pilot Projects in Training Mental Health Counselors
Margaret J. Rioch 110

8. New Manpower for Mental Hospital Service
Richard Sanders 128

9. The Training of Human Service Aides
William L. Klein 144

10. A Neighborhood-Based Mental Health Approach
Frank Riessman 162

11. Psychological Care for the Poor: The Need for New Service Patterns With a Proposal for Meeting This Need
Elmer A. Gardner 185

12. A Mental Health Consultation Program in a Small Community With Limited Professional Mental Health Resources
Charles D. Spielberger 214

IV. NEW APPROACHES IN THE SCHOOLS

13. Preventive Aspects of School Experience
Herbert Zimiles 239

14. Primary Prevention in the Classroom Through a Teaching Program in the Behavioral Sciences
Sheldon R. Roen 252

15. Enhancing the Classroom Teacher's Mental Health Function
William C. Morse 271

16. The St. Louis School Mental Health Project: History and Evaluation
Margaret C.-L. Gildea, John C. Glidewell, and Mildred B. Kantor 290

17. Some Strategies in Mental Health Consultation: A Brief Description of a Project and Some Preliminary Results
Ira Iscoe, John Pierce-Jones, S. Thomas Friedman, and Loyce McGehearty 307

18. Early Identification and Prevention of Emotional Disturbance in a Public School
Melvin Zax and Emory L. Cowen 331

19. Project Re-ED: Educational Intervention in Discordant Child Rearing Systems
W. W. Lewis 352

20. A School District Program for Schizophrenic, Organic, and Seriously Disturbed Children
George T. Donahue 369

V. SUMMARY

21. Emergent Approaches to Mental Health Problems: An Overview and Directions for Future Work
Emory L. Cowen 389

Author Index 457

Subject Index 465

I

INTRODUCTION

1

THE MENTAL HEALTH FIELDS TODAY: ISSUES AND PROBLEMS

Emory L. Cowen and Melvin Zax

University of Rochester

This chapter begins with a review of the historical antecedents of current beliefs and practices in the mental health fields. Beyond that, its purposes are to phrase the questions to which the volume is addressed and to focus on some of the fundamental issues underlying it. The aim is primarily that of exposing relevant problems rather than of trying to speak to their resolution.

HISTORICAL PERSPECTIVES

The history of man's ideas about mental illness and mental health is a long and tortuous one. It has been marked by a series of conflicts, some of which seem rooted in man's need to feel secure and others of which are more strictly intellectual in nature. It seems man was initially drawn to concern himself with behavior only because it went awry. Modern man, like the primitive, proceeds largely under the assumptions that he is in good command of his psychological processes and that he knows just why he behaves as he does. When unreasonable behavior occurs, it demands explanation and attention either because it is troublesome to others or because it may suggest to those who seem outwardly secure that they, too, are vulnerable.

Man's first great struggle in attempting to understand behavioral dysfunction was between the tendency to attribute it to supernatural causes, as was done with most natural phenomena, and the need to look at it closely in an attempt to deal with it rationally (Alexander & Selesnick, 1966). The invocation of spirits involved the assumption that just as some events occurred because man willed them and took steps to cause them, so, too, might such peculiar phenomena as mental illness arise because some powerful spirit, well-intentioned or otherwise, would have it that way. Hippocrates' great contribution was his insistence that rational explanations could be found for mental aberration, and his contemporaries in the golden age of Greece contributed much concrete thought based on such an assumption. Down through the years, however, first the spiritistic, then the rational, idea prevailed; and a variety of factors seemed to determine which held sway. Certainly the state of man's sense of security and safety was a crucially important, determining factor.

As the Roman Empire began to break up and Europe was ravaged by plagues and marauding hordes of barbarians, life became so unsettled that man could not withstand threat while he sought rational solutions. He needed to do something which would bring quick relief and hope. His resolution was to turn to religion, which could bring some immediate order to his existence by prescribing much of his behavior. Even more, though, religion held out the hope of an afterlife in which surcease would be found. With this emphasis on the importance of the supernatural and an afterlife, interest in rational causes of behavior diminished. The rational approach was revived only after Western man began to undergo an intellectual reawakening. This revival, a struggle that continued over many years, began because the restrictions imposed by religious forces came to be more onerous than the insecurity associated with rebellion against the established order. It might be added that the conflict between faith and understanding was never won completely by either side.

When man emerged from the Middle Ages and became more thoughtful about aspects of his own behavior, a new conflict emerged, one which was, in most respects, intellectual. The conflict involved the question of whether man's behavior was to be understood on the basis of his biology or his experiences. While many of those whose primary appeal was to biology took on overtones of spiritism, there has always been a group of such theorists who hewed to a strictly scientific line.

In many ways a biological explanation of behavior, particularly behavior disorder, is an attractive one for man. This is probably so because, on this basis, the person who becomes ill can be regarded as the exception. He is the one with a vulnerable physiological structure. If experiential variables are the main causes of mental illness, then we are all vulnerable. We are all subject to noxious experiences, many of which we are at a loss to control. Thus, mental illness may befall us all. This is an idea that man has found extremely threatening down through the years. His preference has been to ignore it, despite occasional, perceptive reminders, usually from literary sources. Don Quixote, for example, may be seen as a characterization of the rational and irrational forces within all men.

The vulnerability that man has always felt regarding control of his own behavior has, no doubt, been a determining factor in what he has regarded as mental illness, how he has thought about it, and what he had done about it. For most of the history of man, when mental illness was considered, the referent was to extreme or bizarre behavior (Zilboorg & Henry, 1941). Those manifesting such behavior were thought to be men apart, and indeed, they were treated as such. The shameful history of conditions in early mental hospitals and the practices which prevailed in them seems to substantiate this view. Foucault (1965) makes a convincing case for the idea that attitudes formerly held toward lepers were transferred to the mentally ill, so that exclusion from society became the acceptable way to treat the problem. The early hospitals were simply places of confinement to which all of society's undesirables–the beggar, the vagabond, the thief, the lunatic—were sent. The deranged, however, had a special place in such institutions. They were displayed to the public, much as animals in a zoo. They often lived under conditions which can only be compared to those endured by wild beasts, and in fact, they were commonly thought to possess animal-like protection against the worst inclemencies. Even so great a humanitarian as Pinel marveled at "the constancy and the ease with which certain of the insane of both sexes bear the most rigorous and prolonged cold" (Foucault, 1965, p. 74).

Man was slow to accept the idea that the behavior of the deranged was on a continuum with so-called normal behavior, but as his attentions shifted from the grossly peculiar manifestations of the seriously disturbed to the symptoms of the less disturbed (e.g., the neurotic), man developed a new awareness. Even in this instance, early interest was in the most dramatic neurotic syndrome, hysteria, which was usually regarded as an essentially physical condition. In his work on this disorder, Freud formulated and crystallized ideas about the causes of the behavior of all men. Interest in such issues was beginning to appear in the nineteenth century, an era marked by a generally greater feeling of security for man. Though we may question the merits of Freud's specific formulations about behavior, there is no minimizing the significance of his work to the history of development of intellectual thought. He clearly viewed all men as subject to the same forces, biological and experimental, and thus paved the way for the readmission of those with severe mental illness to the human race. Beyond that, however, his work served to refocus the attention of the helping professions, so that their interest and activities began to encompass not only the psychotic, but the less seriously disturbed neurotic as well.

This broadening of the scope of the mental health professions resulted in a spate of new theories about behavior and the recognition of determinants that had not previously been accorded much significance by professionals. The years following Freud's early work witnessed a further enlargement in the range of human behavior which is of concern to the mental health worker. Interest in neurosis led to the recognition of the effects of emotions on physiology and to the development of psychosomatic medicine. Perhaps even more important, a growing awareness of the significance of the so-called ego structures in mental illness sensitized man to greater subtleties in behavior and its potential rooting in early experience. Gradually many of the "givens" of human nature were called into question. We are less certain now, for example, that IQ is entirely related to innate qualities. We are less prone than we used to be to regard certain groups of individuals whose behavior is, in some ways, "primitive" as inherently inferior. As a result, the mental health professions, especially in the United States, seem to be undergoing a new expansion of their horizons. This has not happened because the old problems have been solved; schizophrenia, for example, remains a vexing concern. It has probably come about because man is daring to look at himself more closely than he ever dared before and is willing to admit that there are subtle aspects of his behavior, to which large numbers of individuals are a party and, which concern him.

It would be a mistake to attribute all of the changes in our thinking about mental functioning to the ideas of any single person. History is full of instances where advanced ideas were thrust aside in favor of primitive notions. Intellectual advance requires fertile soil and a proper climate in which to grow, and this seems especially true for man's ideas about his own behavior. Where there is a need for the security that superstitution and magical practices afford, the person who would apply his intellect to the problems of the day is a threat. His approach denies the validity of the supernatural and, whatever success a science achieves, it inevitably confronts man even more with his ignorance. Thus, it is the reasonably secure man who can tolerate rationality in thinking about how and why he acts. Lewis (1941) has gone so far as to assert "It is possible to say that the attitude of a people toward mental disorder is a fairly accurate indication of the stage of civilization attained by them" (p. 24). By such a standard modern man, especially in this country, is advanced indeed. The reasons for this are manifold, but in large measure, they can probably be reduced to the fact that he has achieved a degree of material security never before equaled. Western man no longer need fear for having enough to eat, a safe place to sleep, and protection against the elements. While the social turmoil attending the kind of rapid technological advances being achieved is stressful, the most elemental needs of man are better met today than at any other time in the history of civilization. The primary stresses of the time derive not from a lack either of technology or of understanding of the natural world, but rather from man's failure to have advanced as far in the social sciences as he has in the natural sciences. He is, therefore, for the first time in history, more at the mercy of his fellows than of the natural forces around him.

Wherever man's problems with nature have been well resolved, it is reasonable to expect that his attention will turn to problems with his inner self and his fellow man (Schofield, 1964), and nowhere has this happened more obviously than in the United States. Though a product of Europe, Freud was the adopted son of the United States. Furthermore, the warm reception accorded Freud paralleled other movements within this country which contributed influentially to the manner in which the helping professions have evolved. The historical moment for such acceptance seems to have been ripe. The extensive efforts of Dorothea Dix over a century ago aided the establishment of our earliest state hospitals. Later, through the work of Isaac Ray and particularly as a result of the experiences and writings of Clifford Beers in the very early years of the twentieth century, the mental hygiene movement in this country was founded. With Beers as its guiding force, and with the backing of distinguished professionals of the time, including Adolph Meyer and William James, the mental hygiene movement emerged initially as a pressure group oriented to educating the public and stimulating action to solve the problem of mental illness. Beers' original concern was with improving conditions in mental hospitals, but the primary aims of the movement soon shifted to two other objectives—establishing a program of eugenics to deny parenthood to those who were "manifestly unfit" and promoting the likelihood that children would be provided environments best-suited to their development.

The National Committee for Mental Hygiene, established in 1908 as an offshoot of the mental hygiene movement, succeeded in the furtherance of some of the foregoing aims but failed in others. Its pioneering efforts to establish clinics for children, as one means of dealing early with problems of mental illness, bore fruit. Moreover, the Committee helped to institute the practice of keeping and reporting statistics on patients in mental hospitals and to create an inspection service for mental institutions. On the other hand, many of its proposals, such as aftercare programs for former mental patients and the launching of broad-gauge programs for prevention, failed almost completely to arouse enthusiasm. Despite the work of men like William Healy, who around the turn of the century wrote extensively about the sociocultural roots of delinquent behavior, the time was not yet ripe for attacking a problem of such magnitude (Eisenberg, 1962b). One reason may well have been that the idea of being able to create a social system which could eliminate serious mental disorder was too remote or visionary. Another may have been that great hopes for curing mental illness were being aroused by the development of psychoanalysis and the successes that were being achieved with somatic approaches to disorders like paresis. Finally, psychiatrists themselves were just beginning to win respectability within the medical profession and were not ready to abandon work which seemed to be paying off in order to learn new disciplines and new techniques which might bring uncertain returns.

Marked expansion of interest in the mental health fields in the United States seems to have gained major impetus from the growing acceptance of Freudian principles and practices following World War I. The work of men like Adolph Meyer very likely paved the way for an appreciation of Freudian concepts, particularly the need to view mental illness from the perspective of a lifetime of experiences which contribute to ultimate disorder. At any rate, psychoanalytic ideas flourished in this country and found their way not only into clinical practice but also into such diverse areas as literature, advertising, the arts, etc. (Duhl, 1965). This has been an important development in the popularization of the belief that all men are subject to similar dynamic forces and are equally vulnerable. One consequence of greater acceptance of this notion has been the growing demand for mental health services, particularly psychotherapy—not entirely, however, on the part of those suffering the most serious illnesses. Indeed, by the 1950's, as Hollingshead and Redlich (1958) were able to point out, intensive one-to-one psychotherapeutic approaches had become most widely applied to the relatively well-to-do and better functioning of the patient population. The less affluent and sometimes more seriously disturbed patient, when treated, was being treated far less intensively and often only with somatic methods.

To back off a moment in time, it is also necessary to look at the impact of another significant set of developments on the evolving mental health scene. The present century—marked by a resurgence of man's hostility to man, with supporting technology to make such hostility many times more destructive than ever before—has witnessed two major international conflagrations of disastrous proportions. These conflagrations had important reverberations upon the mental health views of both professionals and the laity. For one thing, specific interminglings of new combinations of people from all walks of life, frequently under highly stressful conditions, graphically exposed many, for the first time, to a systematic view of the vagaries of emotional perturbation. Certain types of acute psychological turmoil and mental illness became much more widely known and, in many situations, became, very concretely, major problems in the lives of individuals and those in close association with them (Bellak, 1964).

As Sanford (1965) has pointed out, some advances were made during World War I with respect to early diagnosis and treatment of emotional disturbance, and, particularly, in furthering acceptance of the doctrine of psychogenic determination of disorder. Our level of concern regarding such problems increased markedly at the time of the outbreak of World War II (Dunham, 1965). Psychiatric screening of potential recruits became much more intensive, and great numbers of individuals were rejected from service as psychologically unfit. Moreover, closer attention was paid to the problem of breakdown during service, and we were further shaken by the finding that nearly half a million servicemen were discharged for reasons of emotional disability. Each of these discoveries served to highlight the magnitude of our mental health needs and the consequences of our past failures to respond to them.

Sarason, Levine, Goldenberg, Cherlin, and Bennett (1966) have noted that two of the major problems growing out of our experiences in World War II were those of the immediate and long-range care of hundreds of thousands of human beings who were psychological casualties of the conflagration. We had neither the resources nor the personnel to discharge these obligations effectively. Awareness of these lacks became a powerful determinant behind the federal government's appropriation of vast sums of money to the Veterans Administration at the end of World War II. The principal objectives of these appropriations were twofold: to provide hospital and out-patient facilities, with their attendant services, for the veteran; and to foster the training of needed mental health professionals in these areas. As such, the VA program —still in force—has represented a powerful influence on the recent growth of the helping professions in this country.

Largely in response to the events of World War II but at an even broader and more basic level, Congress in 1946 passed the National Mental Health Act. This legislation, justifiably regarded by some (Romano, Ch. 2) as the single most important development in the history of the mental health movement, provided a budget for widespread augmentation of facilities and services, the training of professional personnel in all of the helping fields, and comprehensive research in areas relevant to mental health. As an outgrowth of this act, the National Institute of Mental Health was created several years later, and it has served as the principal administrative agency for its implementation. In the years since the enactment of the original legislation, the scope of activities encompassed by the NIMH programs has steadily widened, and its total budget now exceeds one quarter of a billion dollars per year. The contributions of this act and its subsequent emendations to the mental health fields cannot be overestimated.

Nearly a decade after the end of World War II, the need for a comprehensive and critical analysis of the mental health scene, independent of a precipitant so extreme as total conflagration, had crystallized. Accordingly, passage by Congress of the Mental Health Study Act in 1955 established a Joint Commission on Mental Illness and Health with this objective in mind. The specific mandate of the Joint Commission was ". . . to survey the resources and to make recommendations for combating mental illness in the United States" (Joint Commission Report, 1961, p. v). The composition of the Commission, its objectives, the scope of its operations, and the substance of its recommendations have, by now, been detailed many times—most completely, of course, in the constituent volumes and summary (Joint Commission Report, 1961) that constitute its final report. This report, as some observers (Sarason et al., 1966) have commented, served to underscore forcibly the magnitude of our mental health problems, the shortages of qualified professional personnel, and some limitations deriving from entrenched modes of mental health practice. One highly germane aspect of the report was the importance accorded to the community as a potential arena for the engagement of mental health problems.

The significance of the issues addressed by the Joint Commission Report is such that some controversy about its recommendations, almost inevitably, has been generated (Eisenberg, 1962c; Iscoe, 1962; Freedman, 1963; Caplan, 1964; Sanford, 1965). In the main, however, the recommendations have been viewed as sound and forward-looking. As Glasscote, Sanders, Forstenzer, and Foley (1964) have said: "Their report was proclaimed a landmark in the history of the mental health movement in this country" (p. 6). Whether it will prove to be a landmark that future historians merely cite in their dispassionate recording of past events, or one which they come to admire for its great functional significance, is a matter that only time will tell. It is already soon enough to know, however, that the document has been an extraordinarily influential one and that, at least for the next several decades, it is likely to constitute a blueprint in the mental health areas.

The need perceived in the Joint Commission Report to conduct our mental health business closer to the community reflects a series of factors which, collectively, support the logic and merit of such a shift in orientation. Among the most significant of these factors are the changes in treatment approaches with seriously disturbed patients, leading toward the growing realization that confinement need not be a lifetime matter and, thus, toward a more frequent establishment of "open-door" policies in mental hospitals (Eisenberg, 1926b; Williams, 1962; Greenblatt & Levinson, 1965). Perhaps the most dramatic of these changes came with the introduction of a series of chemotherapeutic agents, notably the psychotropic and antidepressant drugs, which created new possibilities for many individuals, both for direct treatment and aftercare in community settings (Bellak, 1964). Another important strand in this development was the increasing awareness of the antitherapeutic forces in total institutions, culminated by Goffman's searching essay (1961), and conversely, the utility—under certain conditions—of the hospital as a therapeutic community (Jones, 1953; Fairweather, 1964; Jarvis & Nelson, 1966). Each of these factors has directed attention toward the community-at-large and its resources as a potential force in combating emotional disorder.

And, finally, there has been an evident current of willingness, even outside of the helping professions, to widen our historically narrow conceptions of the factors which contribute to disorder and the form in which such disorder may be manifested. Thus, the potential linkings of lack of education, poverty, squalor, and the undermining of human dignity with scarring of the psyche have come, more and more, to be viewed as admissible (Clausen, 1966). This latter wave comes from recognizing the paradox of a society struggling to provide more and more opportunities for education, achievement, and the accumulation of material comfort and, at the same time, observing an ever-widening chasm between those who benefit from such opportunities and those who do not (Burgess, 1965). The seriousness of this gulf has become more than a scientific or professional concern. It has prompted the government of this country to create, through massive appropriations of public funds, programs which are aimed at reducing the chasm (Office of Economic Opportunity, 1965) and making it possible for all people to live a more effective, fulfilling, and personally gratifying existence in what has come to be known as the "Great Society." The civil rights movement and a variety of programs sponsored by the Office of Economic Opportunity (e.g., Project Head Start) well exemplify this development. These programs are anchored in the community, and though they are targeted primarily to social problems, their relevance for the mental health areas has not gone unnoticed (Reiff, Ch. 5).

The foregoing factors have contributed to the shift in orientation of mental health professionals toward the community and its primary institutions—a shift which is reflected to some extent in the Joint Commission Report. The fuller impact of this development was dramatized in President Kennedy's February, 1963, address to Congress calling for a new type of mental health facility. As Caplan (1964) comments: "The fact of the message itself—the first official pronouncement by a head of government . . .—as well as its content emphasize that henceforward the prevention, treatment, and rehabilitation of the mentally ill . . . are to be considered a *community* responsibility and not a private problem . . ." (p. 3). The statement by the President presaged enactment of the Community Mental Health Act of 1963, which is to be viewed as a major part-implementation of the Joint Commission Report. This act established the basis for a comprehensive network of community mental health centers around the country to engage mental health problems in a form and manner which departed from long-standing practice in this area. The proposed activities of such centers, both mandatory and recommended, were set down in a series of implementing regulations issued shortly after the enactment of the enabling legislation. Though much has been written about the community mental health center, its implementation, and some of its potential problems (Albee, 1963; Albee, Ch. 4; Caplan, 1964; Glasscote et al., 1964; Smith & Hobbs, 1966), there is as yet little objective basis for its evaluation. The potential importance of the development is such, however, that critical thought and comment about it, as well as intensive, logical analysis of its promise and potential pitfalls, are sorely needed at this time (Felix, 1963; Brown & Cain, 1964).

CURRENT PERSPECTIVES

It is apparent from this brief historical sketch that the past seventy-five years, and particularly the last twenty-five, have seen tremendously rapid and complex developments in the mental health fields. These developments grew out of the age-old concern for the severely ill and came rapidly to encompass wide varieties of behavior which had never before been regarded as being within the province of the mental health worker. Yet, viewed in terms of the total history of man, the mental health movement is still a young one. A great portion of our collective efforts has gone into the establishment and legitimization of the movement—into an implantation of the notion that a mental health orientation represents a fundamental and necessary dimension in the evolution of an optimal society. We have grown up in the image of a particular model, the medical model, which had been demonstrably effective in other areas and had seeming relevance for the management of psychological dysfunction. But, in a panoramic social sense, the essential early struggle of the movement has been largely one of inside versus outside, of respectability versus nonrespectability, or of "pro"-mental health versus "anti"-mental health, rather than an internal struggle among alternative mental health stratagems and pathways. In other words, we have been so busy becoming respectable that we have had neither the time nor the security to look unto ourselves or to support truly critical evaluation of the substance of our efforts.

It is only very recently that the foregoing situation has changed. The mental health movement has, by now, achieved a place of considerable respect and dignity in many quarters of modern society. We are no longer fighting for our professional existence as was Freud sixty years ago. On the contrary, the swing of the pendulum has been such that our current problem is more often that of being oversold and unable to deliver. The past decade has thus been characterized by restlessness, reexamination, and ferment concerning our mental health helping structures and practices (Caplan, 1964; Sarason, et al., 1966) and by a growing interest, on the part of social scientists and public health specialists, in both the theoretical and practical problems reflected in this area (Hobbs, 1964; Caplan, 1965).

While acknowledging a substantial disagreement about the centrality of the various determinants, it is nevertheless possible to approximate a "bill of particulars" that comprises most of the variance of current discontent. In brief, our problems are these: (1) The need for mental health helping services far outstrips available resources; (2) Past practice has resulted in little progress in the treatment of entire classes of disorder; (3) It appears that both the effectiveness and impact of one of the backbone techniques in our helping armamentarium—psychotherapy—has been seriously overestimated; (4) Delivery of mental health helping services has been characterized by profound inequities, with particular reference to variables such as race, social class, education, and geography; and (5) Our modes for delivery of mental health services are, in the main, out of tune with the social reality and life-styles of vast numbers of potential recipients. These are some of the prime issues facing the mental health fields today—issues to which emergent approaches, such as those reported in the present volume, are addressed. In the sections that follow, more detailed consideration will be given to several of these problems.

DEMAND, NEED, AND RESOURCES

Schofield (1964) uses the phrases "the countable thousands" versus "the hidden millions" to point up an important distinction between the *demand* and the *need* for mental health helping services. Though neither term lends itself to ready definition, it is clear that, of the two, demand is both a more conservative concept and *somewhat* easier to specify. Estimates of demand for mental health services are based on statistics such as the number of mental hospital beds occupied, the number of people seeking help through mental health clinics and agencies, and the number seeing private practitioners. In other words, it is possible, at least in part, to be "operational" in speaking of existing demand. However, such figures are subject to many biases, characteristically in the direction of underestimation. For example, one of the reports in the Joint Commission series (Gurin, Veroff, & Feld, 1960) indicates that less than 20% of those who see themselves as needing help with their emotional problems take such problems to mental health specialists. Beyond that, it is well known (Schofield, 1964; Sanua, 1966) that the availability of facilities is a limiting factor on demand figures. That the number of occupied mental hospital beds in the District of Columbia alone is ten times greater than the number in many states reflects geography and available facilities, not incidence or demand (Sanua, 1966). Recognizing the imprecision of any approximation, Nichols (1963) has said: "The total number of people who demand some sort of psychological services . . . (is) . . . at least three million per year, and this is undoubtedly a minimal estimate" (p. 3).

Whatever the difficulties of defining demand for psychological services, they are minimal when compared to the complexities involved in defining need. Few, however, would argue with the assertion that need is far greater than demand. To establish demand requires that the person be seen by himself or by others as having a problem, that facilities for help be available, and that he, or responsible others, be able financially and motivationally to request help. Faltering at any of these points means that the person in question will not be reckoned as a demand "statistic." And, there is every reason to believe that there are many people, with great need, who do falter at one or more of them. Some of these may be among "the recalcitrant 50%-70% of the general practitioner's case-load who are sooner or later labelled 'neurotic' " (Schofield, 1964, p. 5). Others, among the poor, are people who, though beset with serious difficulties, do not define these as psychological or, if they do, find the potential sources of help so inimical that they will not seek assistance. All belong to the "hidden millions" that Schofield (1964) describes —people who are unhappy, ineffective, and oftentimes suffering untold misery, but who are not formally identified as mental health problems in our statistical surveys.

Assessment of need in the mental health area is not unrelated to some very fundamental questions, such as "What *is* a psychological problem?" and "How do we determine its presence?" Perceptions of existing need vary as a function of the stringency of the answers we provide to these questions. On the relatively conservative side, several recent sources (Eisenberg, 1961; Joint Commission Report, 1961; Nichols, 1963) have estimated that roughly 10% of our present population is in need of psychological assistance. By contrast, several epidemiological surveys (Leighton, 1956; Leighton, 1959; Leighton, Leighton & Armstrong, 1964; Srole, Langner, Michael, Opler, & Rennie, 1962) and early detection studies with young children (Cowen, Izzo, Miles, Telschow, Trost, & Zax, 1963; Cowen, Zax, Izzo, & Trost, 1966) report up to one-third of the samples studied as evidencing either some degree of psychiatric symptomatology or moderate to severe pathology. And, perhaps, most extreme of all, the two epidemiological surveys cited above indicate that less than 15%-20% of the rural and urban samples studied (Stirling County, Nova Scotia, and midtown Manhattan) were free of indicants of emotional distress. These findings suggest that, insofar as mental health helping services are concerned, need may well exceed demand by a factor of anywhere from six to twenty.

For the moment, it will be sufficient to consider only the more conservative demand statistics as a basis for evaluating existing resources—particularly available professional personnel. A searching examination of the problem was undertaken by Albee (1959) as part of the Joint Commission series. His key finding relevant to the principal helping professions of psychiatry, social work, and clinical psychology was that the then-existing shortages, using "adequate" rather than "ideal" standards of care as the criterion, ranged from 25% to 75%. Since there are far fewer professionals than needed in the core helping professions, it follows that many positions, whether due to type of setting, location, salary, or some combination of these factors, have remained permanently unfilled. Moreover, as Albee has emphasized, if we combine best estimates of population growth and professional training potential, it seems highly probable that we shall be unable to overcome these deficiencies in either the near or distant future. In fact, as has been suggested (Albee, 1963, Ch. 4), our manpower problem may get worse because of the increasing competition for professional services from agencies and organizations which are relative newcomers to the arena. In the field of psychology, for example, the need for teachers in colleges and universities is increasing so sharply that it is probable that *all* available psychologists could soon be absorbed in this function alone. As a very different case in point, the recommended staffing of our new community mental health centers calls for one psychiatrist, one social worker, and one clinical psychologist per 50,000 population—not at all a luxurious ratio. For a nation of some 200,000,000 people, this means an additional 12,000 fully trained helping professionals in a situation where we are already overtaxed by critical shortages.

The concept of mental health resources, of course, extends more broadly than just professional manpower. The monies available for mental health-relevant activities and programs, our mental hospitals and clinics, and a variety of caretaking agencies are further important elements in the total configuration of helping resources. Nichols (1963), following a review of the current availability of these types of resources, states ". . . it must be concluded that there is a great shortage in the supply of psychological services and that this is the combined result of insufficient personnel, inadequate funds, not enough psychological facilities and too few care-taking agencies. The consequence is inescapable; at present many people get no help and many more get less than they need or get the wrong kind" (p. 5).

The foregoing facts add up to a compelling sum. Merely in terms of demand for mental health services (rather than need which is inferred to be many times greater), present resources, measured by almost any criterion, are grossly insufficient. Moreover, steering the traditional course, it is probable that existing shortages will become more critical over time. The challenge of this situation cannot be ignored. Indeed, its fundamental clarity forces upon us an awareness of a central failing of our mental health order and a sense of urgency about the need for exploring new approaches and ways of doing things which may help to reduce serious existing imbalances between need or demand, on the one hand, and resources on the other. At a logical level, the alternatives for achieving this end are limited. We may strive either to increase manpower and resources or to reduce need through improved technology within our present framework or the development of new conceptualizations about and approaches to mental health problems. Though these pathways are not mutually exclusive, they clearly involve different tactics, stratagems, and emphases. Issues such as how our efforts may best be apportioned in seeking to achieve such objectives and what conceptualizations and approaches seem most promising at this time are among the most significant challenges of the emergent approaches movement and a basic focus of this volume.

Consideration of the foregoing broader issues should help to focus attention on a series of questions pertaining to utilization of nonprofessional and professional manpower in the mental health operation (Duhl, 1965). Speaking first of the former: In what ways does utilization of the nonprofessional relate to our guiding conceptualizations? What kinds of people, both in terms of group belongingness and personal attributes, may be suited for such work? What is the range of mental health-related roles for which the nonprofessional can be prepared? How do we go about training such people? What is the relationship between selection and training factors, on the one hand, and roles and functions on the other? Are there certain contributions that the nonprofessional may be able to make that cannot be made by the professional? What is the effect of participation by the nonprofessional in helping activities, both on the recipient of his services and on himself?

Similar questions must also be raised about the mental health professional, as for example: What new roles and functions must be acquired? How does one go about training for these functions? What sorts of changes will be needed in the apportionment of the professional's time? What should be the relationship between the professional and the nonprofessional? What are the sources of resistance that may be encountered, both from the professionals themselves and from influential training institutions, as we attempt to carve out new roles?

It is certainly easier to associate to such problems than to resolve them. At the same time it is well to have them clearly in mind from the very beginning, since they are issues that will come up repeatedly in later sections of this volume.

PSYCHOTHERAPY: HOPES, DISAPPOINTMENTS, AND ALTERNATIVES

The development by Freud of psychoanalysis as a method for approaching the cure of emotional disorder marked the beginning of a new era for the mental health professions. There was the exciting prospect of being able to deal with psychological problems largely through sophisticated application of techniques of verbal discourse—a major breakthrough in the history of healing. In a relatively short period of time, therefore, psychoanalysis and its derivative approaches in psychotherapy became the primary tools in our helping armamentarium. Indeed, the history of the mental health movement in the twentieth century is dominated by the emergence and growth of psychotherapy, and it is not unfair to say that we have "placed our early bets" on this development. Psychotherapy has come to be valued above all other approaches by many mental health professionals, by professionals in training, and by major groups of potential recipients. Accordingly, other helping methods have frequently been viewed as unsophisticated, palliative, or half-hearted.

A host of factors have contributed to the sometimes unreasoned and reverent adoration of psychotherapy and to its self-perpetuation (Eisenberg, 1961, 1962a; Goldston, 1965). Certainly among the more important of these is the fact that, for the professional, this function serves simultaneously to fulfill a powerful constellation of needs, including those for status and prestige, economic gain, and power and control. The foregoing considerations have contributed to a slowness in, and resistance to, rigorous evaluation.

The decade of the 1950's was the period when the early flush of enthusiasm over psychoanalysis, its derivative psychotherapies, and the therapeutic role that it carved out for helping professionals in all fields began to yield to serious questions about the efficacy of the approach. Perhaps this development came about because some professionals had achieved a certain security with a definite role that was becoming widely honored. Perhaps it derived from a growing impatience with traditional techniques or from the recognition that they failed to answer all mental health problems and that unless challenged, there would be little initiative for trying new approaches. In any case, a provocative and highly controversial paper by Eysenck (1952) presented data suggesting not only that psychotherapy did not positively affect recovery from neurotic disorder but also that intensive therapies appeared to be less efficacious than briefer ones. This position has been extended and updated in subsequent reports (Levitt, 1957; Eysenck, 1961). Though Eysenck's logic and his data have been challenged on numerous occasions (DeCharms, Levy, & Wertheimer, 1954; Rosenzweig, 1954; Cartwright, 1955, 1956; Bindra, 1956), few, including his severest critic (Rosenzweig, 1954), argue that convincing, positive demonstrations of the effectiveness of psychotherapy have been carried out. Schofield (1964) well reflects the current situation in the following statement: ". . . we are still awaiting definitive research—we still do not have acceptable *evidence* that psychotherapy accomplishes significant reduction of neurotic symptomatology, let alone evidence that the several different forms of psychotherapy have different levels of efficacy" (p. 99).

It is often not sufficiently emphasized that evaluation of the clinical effectiveness of psychotherapy is even further biased by the selectivity of the patient group that it touches. Those who seek and obtain psychotherapeutic services are the relatively affluent, the better educated, and the less seriously disturbed in society. Failure to have demonstrated the effectiveness of psychotherapy is therefore even more serious, since evaluations have been based on "more favored" groups. The overall situation is aggravated by the relative inapplicability of psychotherapy to many basic emotional disorders, as well as by its social ineffectiveness and failure to reach major segments of the population in need of help (Riessman, Cohen, & Pearl, 1964).

That psychotherapy remains as a dominant approach today reflects the motivational determinants cited above, plus the fact that, as the starting point of the modern mental health movement, it has been both our great hope and a powerful imprinting force. In speaking to this point, however, Eisenberg (1962a) warns: "The history of science . . . is replete with instances in which an initially liberating conceptualization, once institutionalized, became a barrier to progress" (p. 824). The matter is well put in such terms. Though we are not yet ready to abandon psychotherapy, a rigid adherence to it as the major tool in coping with mental disorder, in the absence of evidence of its clinical efficacy and positive indications that it is socially ineffective, would guarantee lack of progress in our mental health efforts (Caplan, 1965). Here, Eisenberg's further comments (1962a) are most relevant: "The limitations of present therapeutic methods doom us to training care-takers at a rate that ever lags behind the growing legions of the ill, unless we strike out successfully in new directions in the search for cause and treatment. . . . Society can ill afford today's precious overspecialization in which trainees may learn one method even superbly well but a method that ever lags behind the demands placed upon it, while they remain abysmally unaware of the problems besetting the bulk of the mentally ill" (p. 825). The issues which grow out of the foregoing analyses, though they may be posed at several levels, seem clear-cut. How may the effectiveness of existing approaches to psychotherapy be increased? What are the alternatives to psychotherapy? How may we begin to approach pressing and widespread mental health problems which have been totally beyond the scope of psychotherapy? Our initial immersion in and enthusiasm for psychotherapy have lulled us into an unwarranted sense of security that has for too long blinded us to consideration of these vital questions.

Given the inadequacies of mental health resources and the evident limitations of psychotherapy and its kindred healing procedures, one admissible and seemingly "face-valid" alternative is that of prevention. This broad concept, borrowed originally from public health medicine, encompasses a variety of meanings as applied to mental health problems (Eisenberg, 1926b; Bower, 1963, 1965; Caplan, 1964; Sanford, 1965). Primary prevention is designed to forestall the occurrence of disorder, or conversely, it seeks to promote mental health. As such, it has its roots in our basic social systems and influence processes, transcends the knowledge and expertise of the helping professions, and implicates other key disciplines. Secondary prevention has as its aim shortening the duration, impact, and negative after-effects of disorder through heavy emphasis on early detection and treatment. This broad concept encompasses efforts to identify and to deal with dysfunction either as early as possible in the individual's life history or in the course of a given disorder whenever it occurs. These two components of secondary prevention are quite different both philosophically and mechanically. Tertiary prevention is targeted to disorder which is largely irreversible, and its goal is primarily that of keeping impairment minimal. In this instance, the argument can be made that the term prevention is a misnomer. At the same time, it is appropriate to note that a considerable portion of our past efforts in the mental health fields have been in the service of tertiary prevention (Williams, 1962).

Analysis of the problems confronting those concerned with the mental health of modern society suggests a strong need for increasing consideration of the potential of preventive approaches (Felix, 1956; Leighton, 1960; Eisenberg, 1962c; Bower, 1963; Arsenian, 1965; Caplan, 1965; Sanford, 1965), particularly those of primary and early secondary prevention. Our hopes for the future should reside as much, or more, in cutting down the flow of disorder as in developing more effective technologies for undoing damage. On the other hand, Bower's remark (1965) "Prevention is at present a high status word in the mental health fields . . ." (p. 8) reminds us that it is all too easy to espouse platitudes in this area.

It is one thing, then, to hail prevention as a noble cause; it is quite a different matter to implement this cause in the face of obstacles, both within the community and within professional groups, which impede our efforts. Furthermore, even with the best of intentions, the creative task of developing useful programs should not be minimized. Just how does one go about "preventing"? There are few questions that are more cogent in the mental health fields today, and while we shall certainly fall far short of a comprehensive and satisfactory answer to it, one of the prime purposes of this volume is to approach this issue both concretely and abstractly.

INEQUITIES IN DELIVERY OF SERVICES

There has been a sharply growing awareness in recent years that social deprivation is related to rates of occurrence of emotional disorder (Fried, 1964; Clausen, 1966) and that delivery of mental health services is highly disproportionate for various segments of society. Factors including education, financial status, race, geography, and socioeconomic status are critical in this regard. Sanua (1966), in a comprehensive review of a number of surveys and studies pertaining to psychotherapy services, has pointed out that such variables determine, in significant ways: seeking help in the first place, being accepted for treatment, the nature of the help received, remaining in treatment, and prognosis for positive outcome. Much the same can be said for all other types of mental health services (Miller & Mishler, 1964). Where help is most needed, it is typically least available and least effective.

Several classic surveys have demonstrated additional biases related to this same cluster of variables. Some investigators (Hollingshead & Redlich, 1958; Pasamanick, Roberts, Lemkau, & Krueger, 1964) have demonstrated that unfavorable diagnoses such as schizophrenia are more readily applied to those from the lower economic classes than to members of the middle and upper classes. McDermott, Harrison, Schrager, and Wilson (1965) have extended these findings by showing that more pessimistic diagnoses are attached to children of blue-collar workers than to children of white-collar workers. In the area of diagnosis, a fascinating study by Haase (1964) contributes further to our understanding of the problem. This investigator asked sophisticated clinical judges to evaluate Rorschach records of patients. The same protocols were preceded in half the cases by identifying information indicating a middle-class background, education, job, and income and in the other half, by a typically lower socioeconomic class picture. Judges uniformly rated patients sicker when the identifying materials indicated lower socioeconomic background. The related and important question of the meaningfulness of typical psychological tests and assessments procedures with the poor is raised in a number of chapters of the volume by Riessman, Cohen, and Pearl (1964).

At another level, the Midtown Manhattan Survey (Srole et al., 1962) uncovered a huge number of potential patients, particularly among the lower socioeconomic groups, who were not receiving treatment and who could never be accommodated by the limited number of available professional workers. For the poor, when dire moments come, a mental hospital is the outlet of choice. Yet Goffman (1961) and others who have looked into conditions in such hospitals found that many prevailing practices existed primarily to simplify the job of caring for and feeding large numbers of incapacitated people, rather than because they had any therapeutic value. In many cases such practices seemed detrimental to good patient care, and much that passed for "therapy" in the hospital was a form of "window-dressing" for the benefit of outsiders.

There is not only the question of imbalance in delivery of mental health services but perhaps the even more fundamental one of translation of need to demand, which typifies large segments of the populace. For many individuals the development of a felt need for help is inhibited by the way in which they perceive their difficulties and by their basic style of life—the only style they know. The problem of how to introduce a force for adaptation and mental health into the lives of such people is a staggering one, even if we felt secure in knowing how they should be adapting. For this type of intervention there have been *no* good traditional models. As a matter of fact, the model handed down within the medical profession emphasizing the need for a patient with a distinct difficulty is simply not calibrated to those who fail to recognize such a problem. The public health model within medicine has, perhaps, had something more to offer, but even that usually starts with a clear goal in mind—a specific disease entity which needs to be dealt with by specific means. Often in such instances considerable public support for professional efforts can be mustered from those wishing to avoid illness. However, the mental health problem in this area is of another ilk, inhering often in the fact that people fail to find a psychologically impoverished way of life a problem, primarily because they know no other.

The entire difficulty does not lie in the members of the community who would be the objects of mental health interventions. It lies in the professional specialists as well. They have been trained in the traditional scheme, and they, too, know no other way of life (Miller, 1964; Riessman & Miller, 1964). Moreover, the traditional role has allowed them to reap status and, with it, the security of seeming to know what one is doing and why. Moving into work with the heretofore unreached means venturing forth among a social class which is entirely unfamiliar—among a group of people who fail to respond in the fashion expected from patients. They may not be verbal in the manner of the middle class, nor at all impressed by psychodynamic formulations (Schneiderman, 1965). They are less concerned with self-actualization than they are with survival, even under minimally comfortable and gratifying circumstances. As Bredemeier (1964) points out, they are a class considered "inferior" by traditional mental health workers precisely because they do not share the values and concerns of the classes that respond to actions based on psychodynamic formulations. The fact that the mental health fields have contributed little to the resolution of the problems of the lower class is a blight on their record and a central challenge for the future.

SOME ISSUES REVISITED

The singularly influential quality of the Joint Commission Report (1961) has been noted in an earlier section of this chapter. Particularly because of that fact, and now in the light of our review of salient mental health issues and problems, it is important that we reexamine some of its cornerstones in an effort to appraise, more realistically, the promise and failings of the report. The terms *prevention* and *community mental health* appear frequently in the report, and one of its salutary impacts has been to focus some attention on these movements. On the other hand, it would be a serious error to assume that these are the primary emphases of the recommendations. A direct quote from the summary of the report should suffice to make this point clear: ". . . major mental illness is the core problem and unfinished business of the mental health movement and . . . the intensive treatment of patients with prolonged mental breakdowns should have first call on fully trained members of the mental health professions. There is a need for expanding treatment of the acutely ill mental patient in all directions via community mental health clinics, general hospitals, and mental hospitals, as rapidly as psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers, and occupational, physical and other nonmedical therapists become available in the community" (p. xiv).

It is well to underscore the values that are reflected in this pivotal recommendation: (1) that psychosis is the central problem of the mental health fields, (2) that intensive treatment is the method of choice, (3) that our hopes lie in massive augmentation of hospitals, clinics, and the supply of helping professionals, and (4) that the community is significant to the extent that it is instrumental in approaching the problems of "mental breakdown." These values are hammered home time and time again in the course of the final report, and admissible alternatives are, to a considerable extent, eschewed: ". . . the bias of this report [gives] a little discomfort to some . . . who have a strong commitment toward practices and programs aimed at the promotion of positive mental health in children and adults. . . . We have assumed that the mental hygiene movement has diverted attention from the core problem of major mental illness. It is our purpose to redirect attention to the possibilities of improving the mental health of the mentally ill" (p. 242). Quite explicitly, the report goes on to say that its central concern is with ". . . various levels of service, beginning with secondary prevention . . . and continuing through intensive and protracted treatment of the acute and chronically ill" (p. 243).

Serious question must be raised about the fundamental substance of the Joint Commission recommendations. Through its emphasis on secondary and tertiary prevention, it reinforces utilization of a model that has not met with distinguished success in the mental health areas and which may not be well suited for dealing with such problems. Its call for a multiplicative thrust in expansion of facilities and relevant personnel may, therefore, be based on shaky premises. The overriding salience attributed by the report to the problems of major mental breakdown (i.e., psychosis) suggests a point of application in time for our mental health efforts, which may be much too late. Moreover, largely because of the primacy attributed to problems of the psychotic, there is a disconcerting "tunnel vision" for many pathways that demand consideration as part of a comprehensive analysis of our mental health situation: prevention of disorder, the young, the unreached, and positive building for mental health.

It is not that the values reflected in the Joint Commission Report are "bad" ones in the absolute sense. Certainly the problems to which the report speaks are real and pressing. However, the critical issue facing the mental health fields today, given the reality of limited resources, is that of the *relative ordering of many values, each of which may be "good" in the absolute sense.* Critics of the Joint Commission Report (e.g., Caplan, 1964; Sanford, 1965) have been quick to seize on this point and have made a compelling case for the consideration of approaches which seek to prevent the occurrence of disorder. The present authors believe that were we to be guided by the spirit and force of the Joint Commission recommendations, it would leave unexplored some of the most promising pathways toward resolution of mental health problems. We must, therefore, question its sufficiency as a blueprint for our mental health operations in the coming decades.

That the foregoing argument has meaning beyond "armchair philosophizing" is reflected in the passage of the Community Mental Health Act of 1963. This legislation is, perhaps, the major concrete consequence of the Joint Commission recommendations to date. The administrative regulations implementing the act (Glasscote et al., 1964; Smith & Hobbs, 1966) require that every center provide five *essential* types of service: inpatient care, outpatient care; partial hospitalization, emergency care, and consultation and education; and indicate five additional, less urgent, *adequate* activities: diagnosis, rehabilitation, precare and aftercare, training, and research and evaluation. There can be little question that the current American mental health scene is characterized by a "scrambling" to establish such community mental health centers. However, careful scrutiny of the implementing regulations indicates that the force of the movement, in line with the Joint Commission emphasis, is in the direction of trying to cope with manifest "major mental illness." As the listing of essential services suggests, the great proportion of our mental health efforts is preempted for perpetuation, on a more massive basis, of what we have done in the past, with some (important) exceptions: keeping treatment closer to the community and the natural habitat of the patient and attempting to reach disorder and to modify it constructively earlier in the process of its unfolding than has been heretofore possible (Ozarin & Brown, 1965). It is, however, regrettable that this significant and potentially influential development may be so sharply restricted by its underlying assumptions and by the manner in which its prescribed functions are "frozen." It is a legitimate question to ask whether the gains to be derived from the community mental health center movement, as defined, will exceed those that might accrue from other, more flexible utilizations of comparable resources, placing greater emphasis on alternative assumptions and goals, including those of prevention.

About the Volume

The present volume was born of the conviction that traditional approaches to the mental health problems of modern society have, at best, been inadequate. Reduction of the incidence of emotional disorder has failed to keep pace with expansion of the helping professions, greater "sophistication," and improved technology; and this has given rise to a growing need to reexamine our assumptions and practices.

It is not difficult to recognize that the mental health problems confronting us are varied, complex, and deeply rooted. For this reason it would be inappropriate to hope for simple resolutions. Different problems call for different types of attack, and both the need and present state of our knowledge are such that a variety of approaches is to be encouraged. There are no illusions about the comprehensiveness of this volume. As one written largely from the standpoint of the helping professions, it is clearly an oversimplification that fails to accord sufficient attention to relevant and significant determinants from other disciplines ranging from the political (Straetz & Padilla, 1966) to the biological. Certainly, this is a basic failing, but it is one which should not be misconstrued as denial of the importance of a broad-gauge assault on mental health problems.

The principal aim of the introductory chapter has been to identify a set of problems and issues facing the mental health fields today and, in so doing, to define the scope of the volume. Common denominators characterizing succeeding chapters are a deep sense of concern about these issues, a challenging of historically dominant modes of mental health practice, and a willingness to explore new pathways and potentially innovative solutions to long-standing problems. To put the matter less in structural terms and more in substantive ones, the major foci of the volume include: critical reexamination of the assumptions and models that have guided our mental health operations, new ways of utilizing mental health manpower, alternative approaches to the delivery of mental health services, and issues of timing (e.g., children versus adults) and locus (e.g., the community and its primary institutions) of our mental health efforts.

Specific chapters differ, however, with respect to the aspect of the total configuration engaged, the model adopted, and the resolutions offered. Although the volume includes several chapters dealing almost exclusively with conceptual, theoretical, and perhaps, even philosophical matters, in the main it is characterized by an emphasis on concrete programs in action. The latter are clearly not the only ones of their type; they illustrate rather than exhaust existing possibilities. In the aggregate, however, within the guiding framework of the volume, they represent a fairly broad spectrum of approaches.

Part II of this volume includes four chapters which are largely conceptual in their orientation. In Chapter 2, Romano has drawn attention to current social movements in the fields of mental health and illness, how they have come about, and what their aims are. In the chapter that follows, Turner and Cumming (Ch. 3) undertake a comprehensive and critical analysis of the medical model as applied to the mental health fields in an effort to point up some of its shortcomings. An alternative set of assumptions and its derivative practice are then developed. Albee (Ch. 4), following an examination of existing and projected mental health manpower needs, points up the intimate relationship between conceptual models and manpower problems, with suggestions for drastic modification of current approaches. The final chapter in this section, by Reiff (Ch. 5), consists of a searching analysis of the mental health needs of the poor, with particular emphasis on ideological components of the problem and the close links between institutional change and the future of the mental health movement.

The next group of chapters (Part III) present programs describing new sources of mental health manpower and new ways for delivering mental health services in the community. In the first of these, Holzberg, Knapp, and Turner (Ch. 6) describe a project utilizing undergraduate volunteers as companions to chronically ill mental patients in a state hospital. Considerable research data indicating the effects of the program on both the volunteers and the patients is presented. Rioch (Ch. 7) presents a summary of her work on two significant projects: training middle-aged housewives for roles, first, as psychotherapists, and second, as counselors in well-baby clinics and day-care centers. Sanders (Ch. 8) reports a program for training college graduates to conduct socioenvironmental treatment with mental hospital patients. Next, Klein (Ch. 9) gives an account of a training program to prepare teenagers from a hard-core area of Washington, D.C., many with "drop-out" and delinquent histories, for careers in the human services. In Chapter 10, Riessman describes the innovative Neighborhood Service Center, an approach to the mental health problems of the poor based on the rendering of concrete service, social action, and utilization of the indigenous nonprofessional worker. Gardner (Ch. 11) provides data on the incidence and treatment of disorders with the poor based on a county-wide, case-register study and then describes the nature and functions of the Mental Health Team, a combined community effort to combat mental illness among lower socioeconomic groups. In the last chapter of this section, Spielberger (Ch. 12) describes a program, featuring group consultation approaches, designed to deal with the mental health problems of a southern community largely devoid of professional mental health personnel.

Part IV of the volume is directed to work with children and, in particular, emphasizes mental health approaches in the schools. Zimiles (Ch. 13) opens this section with a report of an investigation of the psychological influence of variations in school atmosphere and experience, one form of much needed social-systems analysis. In Chapter 14, Roen presents a program for teaching the behavior sciences, with particular emphasis on psychology, at the fourth-grade level. In the next chapter, Morse (Ch. 15) reports an extensive program of mental health consultation to the schools, designed to increase both the sensitivity of the teacher to problems in the area and her effectiveness in coping with them. Gildea, Glidewell, and Kantor, in Chapter 16, describe several mental health programs in the school, featuring discussion groups for parents conducted by trained lay leaders. Research data on the effects of these programs on parent perceptions and attitudes are presented. Iscoe, Pierce-Jones, Friedman, and McGehearty (Ch. 17) report a program in mental health consultation for teachers and principals manned by graduate students. Evaluation of this program is being undertaken through utilization of a comprehensive test battery and follow-up interviews. In Chapter 18, Zax and Cowen describe a school-based program for early detection and early secondary prevention of emotional disorder, featuring the use of housewives as mental health aides and college students in an after-school, day-care, activity program.

The last two programs of this section differ from the preceding ones in that they deal with more seriously disturbed youngsters outside of the regular school setting. Lewis (Ch. 19) reports on Project Re-ED, which seeks to test the feasibility of utilizing small residential facilities, staffed by specially trained "teacher-counselors," for work with emotionally disturbed children. In Chapter 20, Donahue describes a special program for schizophrenic, organic, and emotionally disturbed children—youngsters who are often candidates for institutionalization or hospitalization—in which housewives are used as "teacher-moms" in a one-to-one relationship with the child. Both the Lewis and Donahue programs are based on the view that proper education is good treatment, both are conducted in a manner that allows for continuing, stable, contact between the child and his family, and both seek to return the child to the normal classroom situation at the earliest possible time.

The concluding section (Part V) consists of a single overview chapter, the purposes of which are to summarize the salient aspects of the volume, to crystallize alternative conceptualizations and their implications, and to offer suggestions for needed future work.

Though many of the programs described in this book are still in an evolutionary state, they are important because they constitute clear-cut illustrations of emergent, changing practice in the mental health sphere and stand as operating models at a time when such models are sorely needed. If this volume helps to promote understanding of these new developments and why they have come about, and if it serves as a meaningful point of departure for future work of this type, then its aims will have been well fulfilled. And, in more optimistic moments, one may even dare to fantasy that certain of its guiding concepts and constituent programs may represent significant harbingers of things to come in the mental health fields.

REFERENCES

Albee, G. W. *Mental health manpower trends.* New York: Basic Books, 1959.

Albee, G. W. American psychology in the sixties. *Amer. Psychol.,* 1963, *18,* 90-95.

Alexander, F. G., & Selesnick, S. T. *The history of psychiatry.* New York: Harper & Row, 1966.

Arsenian, J. Toward prevention of illness in the United States. *Comm. Ment. Health J.,* 1965, *1,* 320-325.

Bellak, L. Community psychiatry: the third psychiatric revolution. In L. Bellak (Ed.), *Handbook of community psychiatry and community mental health.* New York: Grune & Stratton, 1964, Pp. 1-11.

Bindra, D. Psychotherapy and recovery from neuroses. *J. abnorm. soc. Psychol.,* 1956, 53, 251-254.

Bower, E. M. Primary prevention of emotional disorders: a conceptual framework and action possibilities. *Amer. J. Orthopsychiat.,* 1963, 33, 832-848.

Bower, E. M. Primary prevention of mental and emotional disorders. In N. M. Lambert (Ed.), *The protection and promotion of mental health in schools.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public No. 1226, 1965, Pp. 1-9.

Bredemeier, H. C. The socially handicapped and the agencies: a market analysis. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor.* New York: Free Press, 1964, Pp. 98-112.

Brown, B. S., & Cain, H. P. The many meanings of "Comprehensive." *Amer. J. Orthopsychiat.,* 1964, *34,* 834-839.

Burgess, M. E. Poverty and dependency: some selected characteristics. *J. soc. Issues,* 1965, *21,* 75-97.

Caplan, G. *Principles of preventive psychiatry.* New York: Basic Books, 1964.

Caplan, G. Community psychiatry—introduction and overview. In S. E. Goldston (Ed.), *Concepts of community psychiatry: a framework for training.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1319, 1965, Pp. 3-18.

Cartwright, D. S. Effectiveness of psychotherapy: a critique of the spontaneous remission argument. *J. counsel. Psychol.,* 1955, 2, 290-296.

Cartwright, D. S. Note on "changes in psychoneurotic patients with and without psychotherapy." *J. consult. Psychol.,* 1956, *20,* 403-404.

Clausen, J. A. A sociological perspective. In R. Brockbank & D. Westby-Gibson (Eds.), *Mental health in a changing community.* New York: Grune & Stratton, 1966, Pp. 13-17.

Cowen, E. L., Izzo, L. D., Miles, H., Telschow, E. F., Trost, M. A., & Zax, M. A preventive mental health program in the school setting: description and evaluation. *J. Psychol.,* 1963, *56,* 307-356.

Cowen, E. L., Zax, M., Izzo, L. D., & Trost, M. A. Prevention of emotional disorders in the school setting: a further investigation. *J. consult. Psychol.,* 1966, *30,* 381-387.

DeCharms, R., Levy, J., & Wertheimer, M. A note on attempted evaluations of psychotherapy. *J. clin. Psychol.,* 1954, *10,* 233-235.

Duhl, L. J. The psychiatric evolution. In S. E. Goldston (Ed.), *Concepts of community psychiatry: a framework for training.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1319, 1965, Pp. 19-32.

Dunham, H. W. Community psychiatry: the newest therapeutic bandwagon. *Arch. Gen. Psychiat.,* 1965, *12,* 303-313.

Eisenberg, L. The strategic deployment of the child psychiatrist. *J. child Psychol. & Psychiat.,* 1961, 2, 229-241.

Eisenberg, L. Possibilities for a preventive psychiatry. *Pediatrics,* 1962, *30,* 815-828. (a)

Eisenberg, L. Preventive psychiatry. In D. Rytand & W. P. Creger (Eds.), *Annual review of medicine.* Vol. 13. Stanford, Calif.: Annual Reviews, Inc., 1962, Pp. 343-357. (b)

Eisenberg, L. If not now, when? *Amer. J. Orthopsychiat.,* 1962, 32, 781-793. (c)

Eysenck, H. J. The effects of psychotherapy: an evaluation. *J. consult. Psychol.,* 1952, *16,* 319-324.

Eysenck, H. J. The effects of psychotherapy. In H. J. Eysenck (Ed.), *Handbook of abnormal psychology.* New York: Basic Books, 1961, Pp. 697-725.

Fairweather, G. *Social psychology in treating mental illness: an experimental approach.* New York: Wiley, 1964.

Felix, R. H. The strategy of community mental health work. In *The elements of a community mental health program.* New York: Milbank Memorial Fund, 1956, Pp. 36-46.

Felix, R. H. Community mental health. *Amer. J. Orthopsychiat.,* 1963, 33, 788-793.

Foucault, M. *Madness and civilization.* New York: Random House, 1965.

Freedman, A. M. Beyond "Action for Mental Health." *Amer. J. Orthopsychiat.,* 1963, 33, 799-805.

Fried, M. Social problems and psychopathology. In *Urban America and the planning of mental health services.* New York: Group for Advancement of Psychiatry, 1964, Pp. 404-446.

Glasscote, R. M., Sanders, D., Forstenzer, H. M., & Foley, A. R. *The community mental health center: an analysis of existing models.* Washington, D.C.: Amer. Psychiat. Ass'n., 1964.

Goffman, E. *Asylums.* Garden City, N.Y.: Doubleday, 1961.

Goldston, S. E. Training in community psychiatry: a survey report of the chairmen of medical school departments of psychiatry. In S. E. Goldston (Ed.), *Concepts of community psychiatry: a framework for training.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1319, 1965, Pp. 185-194.

Greenblatt, M., & Levinson, D. J. Mental hospitals. In B. Wolman (Ed.), *Handbook of clinical psychology.* New York: McGraw-Hill, 1965. Pp. 1343-1359.

Gurin, G., Veroff, J., & Feld, S. *Americans view their mental health: a nationwide interview survey.* New York: Basic Books, 1960.

Haase, W. The role of socioeconomic class and examiner class in examiner bias. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor.* New York: Free Press, 1964, Pp. 241-247.

Hobbs, N. Mental health's third revolution. *Amer. J. Orthopsychiat.,* 1964, *34,* 822-833.

Hollingshead, A. B., & Redlich, F. C. *Social class and mental illness: a community study.* New York: Wiley, 1958.

Iscoe, I. The final report of the Joint Commission on Mental Health: implications for clinical psychology. *J. clin. Psychol.,* 1962, *18,* 110.

Jarvis, P. E., & Nelson, S. E. The therapeutic community and new roles for clinical psychologists. *Amer. Psychol.,* 1966, *21,* 524-529.

Joint Commission on Mental Illness and Health. *Action for mental health.* New York: Basic Books, 1961.

Jones, M. *The therapeutic community: new treatment method in psychiatry.* New York: Basic Books, 1953.

Leighton, A. H. *My name is legion: foundations for a theory of man in relation to culture.* New York: Basic Books, 1959.

Leighton, A. H. *An introduction to social psychiatry.* Springfield, Ill.: Charles C Thomas, 1960.

Leighton, D. C. Distribution of psychiatric symptoms in a small town. *Amer. J. Psychiat.,* 1956, *112,* 716-723.

Leighton, D. C., Leighton, A. H., & Armstrong, R. A. Community psychiatry in a rural area: a social psychiatric approach. In L. Bellak (Ed.), *Handbook of community psychiatry and community mental health.* New York: Grune & Stratton, 1964, Pp. 166-176.

Levitt, E. E. The results of psychotherapy with children: an evaluation. *J. consult. Psychol.,* 1957, *21,* 189-196.

Lewis, N. D. C. *A short history of psychiatric achievement.* New York: Basic Books, 1941.

McDermott, J. F., Harrison, S. I., Schrager, J., & Wilson, P. Social class and mental illness: observations of blue collar families. *Amer. J. Orthopsychiat.,* 1965, *35,* 500-508.

Miller, S. M. Social class, mental illness, and American psychiatry: an expository review. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor.* New York: Free Press, 1964, Pp. 11-15.

Miller, S. M., & Mishler, E. G. Comparison of experience and behavior of lower and higher status groups: findings and hypotheses. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor.* New York: Free Press, 1964, Pp. 16-38.

Nichols, R. S. The influence of economic and administrative factors on the type and quality of care given to persons with psychological disease. *Working Papers in Comm. Ment. Health,* 1963, *1,* 1-34.

Office of Economic Opportunity, *Catalogs of federal programs for individual and community improvement.* Washington, D.C.: Office of Economic Opportunity, 1965.

Ozarin, L. D., & Brown, B. S. New directions in community mental health programs. *Amer. J. Orthopsychiat.,* 1965, *35,* 10-17.

Pasamanick, B., Roberts, D. W., Lemkau, P. W., & Krueger, D. B. A survey of mental disease in an urban population: prevalence by race and income. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor.* New York: Free Press, 1964, Pp. 39-48.

Riessman, F., Cohen, J., & Pearl, A. *Mental health of the poor.* New York: Free Press, 1964.

Riessman, F., & Miller, S. M. Social change versus the "psychiatric world view." *Amer. J. Orthopsychiat.,* 1964, *34,* 29-38.

Rosenzweig, S. The effects of psychotherapy: a reply to Hans Eysenck. *J. abnorm. soc. Psychol.,* 1954, *49,* 278-304.

Sanford, N. The prevention of mental illness. In B. Wolman (Ed.), *Handbook of clinical psychology.* New York: McGraw-Hill, 1965, Pp. 1378-1400.

Sanua, V. D. Sociocultural aspects of psychotherapy and treatment: a review of the literature. In L. E. Abt & L. Bellak (Eds.), *Progress in clinical psychology.* Vol. VIII. New York: Grune & Stratton, 1966, Pp. 151-190.

Sarason, S. B., Levine, M., Goldenberg, I. I., Cherlin, D. L., & Bennett, E. M. *Psychology in community settings.* New York: Wiley, 1966.

Schneiderman, L., Social class, diagnosis and treatment. *Amer. J. Orthopsychiat.,* 1965, *35,* 99-105.

Schofield, W. *Psychotherapy: the purchase of friendship.* Englewood Cliffs, N.J.: Prentice-Hall, 1964.

Smith, M. B., & Hobbs, N. The community and the community mental health center. *Amer. Psychol.,* 1966, *21,* 499-509.

Srole, L., Langner, T. S., Michael, S. T., Opler, M. K., & Rennie, T. A. C. *Mental health in the metropolis.* Vol. I. New York: McGraw-Hill, 1962.

Straetz, R., & Padilla, E. Problem oriented political science in mental health *Comm. Ment. Health J.,* 1966, *2,* 109-113.

Williams, R. H. (Ed.) *The prevention of disability in mental disorders.* Washington, D.C.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 924, 1962.

Zilboorg, G., & Henry, G. W. *A history of medical psychiatry.* New York: Norton, 1941.

II

CONCEPTUALIZATIONS

2

PSYCHIATRY, THE UNIVERSITY, AND THE COMMUNITY

John Romano

University of Rochester Medical School

One of the most dramatic ways to emphasize the intensity, magnitude, and acceleration of the social movement in the general field of mental health might be to quote briefly from a report received recently from colleagues in Cali, Colombia–Professor Carlos Leon and his associate, Professor Ernesto Zambrano. The latter served in the Department of Psychiatry of the University of Rochester Medical Center for two years. They report the changes which have occurred in their university over the past eight to nine years. An excerpt points out, for example,

> . . . that the only place where clinical teaching could be conducted, ten years ago, was in an asylum, since no other facilities existed in Cali for the care of psychiatric patients. In previous years the patients had been gathered in vacant lots surrounded by barbed wire fences where they idled naked and in utter promiscuity. Diagnostically, they included psychotics, epileptics, mental defectives, as well as cripples and invalids of all kinds. At Asilo, San Isidro, the historical span of progress in the care of psychiatric patients is much narrower than that of Europe or the United States. San Isidro has moved 200 years during the past eight to nine years. Eight years ago, it was a human garbage pail for the unwanted mentally ill and mentally defective human beings of el Valle. Here the police literally dumped these disabled people over the wall into the enclosed compound of the hospital. Often bones were broken in the fall to the ground. Acutely disturbed patients were chained to the floor of dirty cells, or placed in straight jackets and given cold showers with hoses. The emphasis was directed toward protecting the personnel rather than toward protecting the patients. Care was custodial, enforced incarceration under the most unsanitary conditions, with minimal emphasis on therapeutic rehabilitation. The philosophy of care was based on the adage, "where there is no sense, there is no feeling."[1]

In the few years that have passed, these two young men and their associates have accomplished a prodigious task in the undergraduate teaching of medical students, in changes in patient care, in the graduate teaching program, and in the preliminary investigative work of social problems such as predominant trends of behavior in Colombian adolescents, psychosocial factors in prostitution, marital stability in a sample of urban families, predominant attitudes of medical students, and the adaptive problems of a group of North American housewives in Latin America.

---

[1] Personal communication.

This type of rapid development should be pointed out because there are those who say that unlike other disciplines in the medical field, within which there has been a progressive spiral of improvement, much activity in psychiatry is apt to be circular. We have had certain cycles of humanitarian reform, but fundamentally we have not made as much progress as have our colleagues in other disciplines. There were the changes that occurred in ancient Greece, in the beginning of the Renaissance, in the period of Enlightenment, and during the tremendous wave of humanism. A century ago there was the great social revolution in the mental hospitals of our own nation initiated by the intrepid, resolute figure of Dorothea Lynde Dix. Now we have our own period in which there is considerable excitement, interest, and vigor in bringing about changes in the whole nature of the problems relating to mental health and illness. It is to the latter that the remainder of this presentation will be addressed. An attempt will be made to share with you certain ideas which the writer believes have been significant in contributing toward the intensity, magnitude, and direction of the social change that is implicit in much of the current mental health movement.

Perhaps a word about the sample of experiences to be included is desirable, since most of what will be discussed is based on personal experience.[2] In the past thirty years the author's principal engagement has been in teaching, patient care, and clinical investigation in a number of university psychiatric clinics and hospitals. In two assignments, Cincinnati and Rochester, there has been considerable opportunity to learn about community agencies and hospitals, both public and private, their planning, and their practices. In addition, the author has had the privilege to study and visit in a number of clinics and hospitals in the United States, the United Kingdom, continental Europe, the Soviet Union, and the Middle East. He has also had the privilege to participate in the past fifteen years in governmental agencies and private foundations in the allocation of funds for teaching, research, and patient care.

A tremendous change has taken place in medical education in the past twenty years. This is reflected in the size, complexity, and responsibilities of departments of psychiatry in American medical schools. We have moved from departments of four or five full-time persons to departments of forty to sixty full-time persons, with comparable increases in the number of resident staff, part-time and volunteer staff, psychologists, social case workers, social scientists, and biologists. Furthermore, there is an extensive research program in many departments.

---

[2] Much of this material is derived from the Eighth Annual Albert D. Lasker Lecture given by the author (Romano, 1965).

Second, a tremendous change has taken place in psychiatric units in general hospitals. This has determined certain aspects of our present movement. Prior to 1800, there were two general hospitals in the United States which accepted psychiatric patients as part of their service to the community. In 1900, there were 19. There were 32 in 1920 and 170 in 1945. Currently, there are about five hundred psychiatric units in general hospitals and an additional five hundred hospitals that admit psychiatric patients without designated units. Eighty per cent of these units began to admit patients after 1947. The steepness of the curve is shown by the recent changes in the number and nature of general hospital units. In 1963 fairly reliable data indicate that more psychiatric patients were treated in psychiatric wards of general hospitals than were admitted to state and county mental hospitals. Ten per cent of these general hospital patients were transferred to public mental hospitals; one per cent to private mental hospitals. Only one out of three of the five hundred general hospitals extant has significant affiliations with a medical school (Glasscote & Kanno, 1965).

Perhaps these points could be better understood if they were projected into the larger pattern of change in American health services, research, and education. It is generally conceded that change has been greater in the twenty years since World War II than during any other period in the history of American health services, including the two decades which followed the remarkable Flexner report in 1910. Psychiatry has shared in this period of incredible change.

Early in the century psychiatric education and research were conducted and pursued by individuals, most of them on a part-time basis at the universities, usually unaided by university funds or external grants. In the second part of the century, private American foundations, the Rockefeller Foundation particularly, contributed funds to support education of the medical student and the furtherance of psychiatric research. It is the writer's belief that the single most significant factor in the growth of American psychiatry in the past twenty years was the action of the 79th Congress in 1946 in passing the National Mental Health Law. This made possible the establishment of the National Institutes of Mental Health and the extramural programs which support undergraduate and graduate education and allowed for additional research. The expansion and liberalization of health insurance programs provided for inpatient cost coverage of patients admitted to psychiatric units. Another political action of significance was the Hill-Burton Hospital Law with provisions making possible federal matching funds for the building of psychiatric services in general hospitals.

Yet, other factors are involved. Many people have remarked how uniquely American is the intensity of our interest in the study of psychology and the social sciences, points often made by Mr. Conant and others who have compared America with the modern European scene. Some imply that this interest stems from our naïveté or optimism, our continuing belief in the modifiability of man. We believe that man is educable, and through his capacity to deal in natural cause and event sequences, he is able to accumulate knowledge and experience and apply these to solve his problems and to advance his welfare. The mental health movement itself has drawn from the traditional Hippocratic frame of reference, from the roots of Western humanism, and from modern science. Others speak of our relative freedom from starvation and the ravages of catastrophic disease, our high standard of living, our greater freedom from, or nakedness of, traditions, the speed and volume of communication, the fact that for four centuries we have been and are a nation of immigrants—all have been suggested as determinants of our vigorous and sustained interest in the study of the social sciences, psychology, and mental health.

It is also generally agreed that psychoanalytic psychology has had a greater impact on psychiatry and on general medical education in the United States than in other nations. This provided not only a set of notions concerning the nature of mental illness and the treatment procedures to correct illness but also opportunities to learn more of normal behavior and to accumulate data toward a general human psychology.

Also, the experiences of World War II, as they related to selection, performance, and rejection of military personnel, and an increasing awareness of social and psychological factors in the onset, modification, and course of illness are thought to have been of consequence in the increasing interest in psychiatric careers. In the past fifteen years, the total number of psychiatrists in practice has increased from about 7,500 to about 15,000. Half of these are in private practice, and as was noted earlier, a significant and increasing number hold full-time university positions in departments of psychiatry at both senior and junior levels. With these changes, it is neither strange nor unexpected that the psychiatric service in the general hospital plays an increasingly prominent part in the current planning for mental health services in the community.

In general, some of the objectives at the moment are the following: reducing the size of public mental hospital services; increasing general hospital services; promoting greater community participation in preventive, reconstructive, and rehabilitative measures. There are those, quite properly, who have posted caveats on some of the uncritical, evangelical aspects of movement toward community mental health centers, at times with very little regard to the fact that there is at the moment very little useful knowledge that has helped us to reduce the chronic populations of schizophrenic and cerebral arteriosclerotic patients. The caveats posted by Dunham (1965), Zwerling (1963), and others should be respected and identified for what they are. They are hard-headed, realistic cautions to us to have a full view of what we are doing so that our community planning may be done intelligently and with empiric, informed data, rather than through evangelical wish alone.

In addition to the three objectives noted above, we also should view the movement variably called community, social, preventive, or public health psychiatry. Zwerling (1963), more than anyone, has outlined clearly the operational criteria for community mental health programs. He has stated that "a community mental health program can be differentiated from a traditional program on the basis of four operational criteria: subjects for study are populations or groups of individuals seen as members of social groups rather than individuals seen in isolation. Next, traditional genetic developmental, psychodynamic formulations of etiological factors in illness are supplemented by data concerning the social determinants of behavior. These are data concerning families, small groups, community, national, social class, and cultural dynamics. Third, the approaches stress preventive and rehabilitative as well as direct therapeutic efforts: case finding and early treatment, in addition to the treatment of full-blown cases of illness; the widest use of community resources and non-psychiatric agencies and agents, rather than the exclusive use of psychiatrists; small, open community-based active treatment hospitals rather than large, security-oriented, geographically remote custodial institutions; and brief, rather than long-term programs of psychotherapy. Treatment techniques include supportive, clarifying or interpretive intervention in family, group, and community processes as well as in individual intrapsychic processes" (Zwerling, 1963, p. 15). He mentions that instances at either extreme of the continuum from individual to community psychiatry are readily enough distinguished; on the other hand, this is the case with any continuum, a range exists over which the differentiation is arbitrary and, perhaps, without signifiance.

Zwerling, Dunham, and many others have pointed to a number of other factors which are playing a part in the current social movement in psychiatry. With increasing size and complexity of communities, a number of people believe that planning can no longer be elective or idiosyncratic. Planning becomes obligatory to avoid unnecessary duplication of services in providing for proper regional distribution for economic and other purposes.

Second, there appears to be a movement to return responsibility for the care of the mentally ill to local communities, from which it had been taken a century ago by state governments. In most states, with the exception of Wisconsin and a few others, county responsibilities or local responsibilities were assumed by state governments for good reasons. The movement today is an attempt to return to the communities the direct responsibility for the operation and fiscal support of the mentally sick. This is aided and supported by the promise of additional federal funds for the development of community health centers through the recommendation of the Joint Commission Report and recent legislation.

Next, war and postwar experiences have, out of necessity, produced modifications in the care of psychotic patients in England, Holland, and other continental countries following the bombing and destruction of many hospitals. Much of the home care was developed because there were no available hospitals. Sivadon in Paris and the Soviet city plans have attempted to serve certain populations in urban areas.

As mentioned earlier, the development of insurance programs and the increase in the number of psychiatric units in general hospitals has also had an impact. The recent action of the United Auto Workers will provide insurance provisions for the care of ambulant psychiatric patients in many of the outpatient clinics of our nation. The tremendous influences of the use of psychotropic drugs and the consistent usefulness of electroshock treatment in depressed patients are clearly evident.

Next, we might consider the whole interest in paramedical groups. This has emerged from an imperative need to examine, empirically and operationally, the roles of certain professional people. Crises have occurred in the identity of the nurse and of the social caseworker. This has touched the American social casework scene and has led us to examine who is the social caseworker, and what are her responsibilities in the modern scene. This examination is going on in schools, industries, hospitals, foster homes, and other areas where new types of health care persons are urgently needed. Do we need to examine more systematically certain operations and from such operations to evolve the kinds of people who will be needed?

The increasing usefulness and awareness of short-term therapeutic ventures, particularly at points of crisis, and the development throughout the nation of emergency walk-in and first aid services has been considerable. Currently, in the Department of Psychiatry at the University of Rochester Medical Center there is a twenty-four hours a day, seven days a week, fifty-two weeks a year emergency service which admits patients, provides first aid, and gives care. Currently, there are fifteen to eighteen visits a day to this service. We need a critical examination of the actual usefulness of long-term versus short-term therapeutic measures. There is also a general awareness of the rediscovery of the human family and of the human community, with the increasing participation of social and behavioral scientists in the field of mental health and illness.

The changes which have been described here are of concern to many. There are those who feel that we may lose the baby with the bath water if we depart too far from our traditional primary concern for the sick person and his family and reach out toward larger social groups with their economic and political repercussions. In the writer's view, however, clinical psychiatry will always be fundamentally concerned with the clinician's capacity for human intimacy, as this is disciplined and developed in his professional education. It is hoped that contributions to our field may come from many sources: from molecular biology at one extreme, from refined studies of social systems at the other. It is hoped that clinical psychiatry will maintain its identity and be nourished by contributions from both extremes. It must be the function of universities to distinguish between craft and profession. This means, then, that we must constantly try with imagination and courage to organize and use intelligence in new ways in order that we may add to our knowledge, to our skills, and hopefully to our usefulness to society.

REFERENCES

Dunham, H. W. Community psychiatry. *Arch. gen. Psychiat.*, 1965, *12*, 303-313.

Glasscote, R. M., & Kanno, C. K. *General hospital psychiatric units.* Washington, D.C.: Amer. Psychiat. Ass'n., 1965, Pp. 59.

Romano, J. Psychiatry, the university and the community. Eighth Annual Albert D. Lasker Lecture. *Arch. gen. Psychiat.*, 1965, *13*, 395-402.

Zwerling, I. Program of community and social psychiatry. N.Y. State Dept. of Health, *Health News,* 1963, *40,* 14-19.

3

THEORETICAL MALAISE AND COMMUNITY MENTAL HEALTH

R. Jay Turner and John Cumming
Mental Health Research Unit, Syracuse, New York

The term *community mental health*, in its currently popular usage, is by no means a unitary concept. Its referents are at least as varied as the propositions and orientations that contribute to its present significance. To a considerable extent these contributing elements are parts of three general developments.

The first is the advent of effective psychotropic drugs, making it possible to consider treatment of the mentally ill in the community with the hope that recovery will be facilitated if the patient's usual environment is disrupted as little as possible. There is growing out of this, a change in philosophy of care and treatment that is tending to shift the locus of the mental health problem from the hospital to the community. As Freeman and Simmons (1963) have noted, ". . . it is no exaggeration to observe that the major problem in the field of mental illness is not the hospitalized but the formerly hospitalized patient" (p. 1).

Second, there is now a political and social climate within which the development of human potential is taken to be a reasonable goal. This orientation is influenced by the recognition that there are many "disordered" but untreated individuals in the community, and that among the ill, whether diagnosed or undiagnosed, treated or untreated, the disadvantaged are disproportionately represented. It also derives from the more general recognition that there are vast numbers among the poor who have important and pressing needs, but who have never been reached by mental health programs.

Finally, among a number of mental health professionals there is a feeling of strong dissatisfaction and disappointment with current psychiatric practice. This feeling is generated by the continued absence of demonstrated effectiveness of treatment, even among those regarded as treatable, and a recognition that psychiatry has retreated before the challenge of severe disorder. Frustrated by failure, clinicians have turned away from the hospitalized patient and the seriously disturbed ex-patient and focused most of their attention upon the mildly impaired middle- and upper-class individual. It is only with this group, in search of self-actualization, that the therapist's technology may retain an image of utility.

Although these elements are by no means unrelated, their differential salience accounts for much of the ambiguity regarding the proper domain for community mental health. Some view this movement as a revolution that promises to rehabilitate a sick society, while others are simply intent on improving methods and facilities already available for individuals who seek care; some are concerned with preventing the development of mental disorder in entire populations, while others are concerned with rehabilitating already disordered patients; and finally, some imagine mental health practitioners in a series of radically different roles, while others project the traditional conception of the therapist-patient relationship into the intended community settings.

With such variability in views and expectations, any theoretical discussion is likely to appear similarly variable in its application or relevance. This chapter makes no systematic attempt to discuss all the various conceptions and programs associated with community mental health. Our primary aim is to examine a pervading and influential preconception regarding human functioning that we believe provides an important demarcation between programs that are basically innovative and experimental and those likely to amount to little more than "old wine in new bottles."

It is not uncommon to encounter serious questioning of the adequacy and appropriateness of the dominant modes of conceptualizing psychological functioning and disorder. A prime example of such dissent may be seen in what Szasz (1961) and others have called the medical model of behavior disorders. While meanings attached to the term *medical model* vary substantially, many dissenters, including several contributors to the present volume, share a general discomfort born of the recognition that their conceptualizations, programs, techniques, and results are not comprehensible within the medical model, however understood.

The focus of this chapter, then, is the medical model and some underlying assumptions that are more pervasive than the model itself. We shall examine this model and its assumptions and discuss what seems to have been their retarding effects upon both theoretical and practical progress. We shall attempt to lend substance to the notion that emergent educational, problem-solving, or "action" programs for mental health are, in certain respects, incompatible with the medical model and to outline the beginnings of an alternative orientation more congenial to such efforts.

THE MEDICAL MODEL

It may be well at the outset to specify what we understand by the medical model as applied to mental health problems. We take it to refer to that broad domain in which attitudes, hypotheses, and expectations are derived from the premise of an analogy between psychological disorder and physical illness. It is the model that earnestly subscribes to the aphorism that mental illness is a sickness, just like any other, and it seems to anticipate a discovery of the specific pathogenic agents associated with the various mental disease entities.

In its most extreme application, the medical model is one that exhibits a special affinity for "real" medical procedures such as surgical intervention, insulin shock, electroshock, and a primary reliance upon drugs. In its more common and less severe form, it takes a position that mental health can be defined as the relative absence of pathology and that ill health is any major deviation from this norm. The medical model includes as instances of mental disorder such deviations as learning difficulties, stress reactions, sexual deviation, mental deficiencies, antisocial behavior, and innumerable other problems listed in the *Diagnostic and Statistical Manual of Mental Disorders.* It is a model from which the frequently-heard caution necessarily follows that one should not confuse symptom and disease; behavior is only important for what it shows and not for what it is. Within this orientation, it follows that the only efficacious long-range course is to uncover and treat the pathogenic source of the disorder, whether this source be physiological or experiential.

Finally, on a more fundamental level, the medical model reflects the belief that psychological functioning, like biological functioning, can be ultimately comprehended as ordered systems of closed, mechanical, reactive phenomena.

A corollary to this frame of reference has been a general maintenance of the classical, one-to-one, physician-patient relationship. This is the relationship of an authoritative agent acting with a receptive patient who, as with organic disease, takes the traditional sick role. Evidence suggests, however, that this role may be the most inappropriate or even damaging of all possible roles for a person having psychological difficulties (Scheff, 1963; Glass, 1953, 1955).

That there are relationships between some specifically physiological dysfunctions and psychological dysfunction cannot be denied. Certainly profound mental changes can be produced by injury, disease, aging, nutritional deficiencies, anoxia, and toxin, just as severe social stress can alter body physiology, producing conditions such as ulcers, thyroid dysfunction, or disturbances in brain metabolism. Also, there remains the possibility of variable genetic predispositions to break down in the face of emotional stress. While it is appropriate that the physical aspects of disorder be viewed medically and treated physiologically, the core of psychological disorder is of a different nature.

Psychological disorders represent level-of-organization phenomena in the psychosocial domain that cannot be attributed reductionistically either to physiochemical pathogens or to a specific early experience. There seem to be no etiological or epistemological manipulations that can provide any other argument. The explicit attitude or mental habit of viewing behavioral deviations as symptoms of some inner pathogenic element, which must be identified through accurate diagnosis in order to know how to treat it, reflects an assumption that organic disease and psychological disorder are structurally and etiologically isomorphic. Such an assumption is neither theoretically nor experimentally defensible.

The above is the often-expressed view that the medical model simply does not describe psychological disorder—that, in this domain, it is not "truth." But the truth of a theory is not the relevant issue. Theories are never true or false; they are only more or less useful. Based upon this point of view, we will, in a later section, argue the general disutility of the medical and similar models and sketch an alternative orientation.

The present discussion might, thus far, be construed as another of the many attacks upon the institutionalized priority of medical and psychiatric practitioners in the area of psychological disorder. This is not, however, our objective. The comments that have been made clearly transcend professional lines. They do not apply to all psychiatrists and are regarded as directly relevant to a majority of psychologists, social workers, and other mental health professionals. While many nonpsychiatric mental health specialists have rejected obvious tenets of the medical model, they have not discarded a prior and similar assumption that has been widely held with significant consequences since the Enlightenment. This assumption is reflected in Whitehead's (1925) thesis that modern science is not nearly so emancipated from medieval modes of thought as is generally supposed. Having argued that a primary and necessary characteristic of the scientific mentality is an "instinctive faith" in the order of nature, he traces the rise of such a faith and concludes that the Middle Ages can be viewed as ". . . one long training of the intellect of Western Europe in the sense of order." In elaborating the medieval contribution to the formation of the scientific movement, Whitehead points to ". . . the inexpugnable belief that every detailed occurrence can be correlated with its antecedents in a perfectly definite manner, exemplifying general principles." The transformation from the "age of faith based on reason" to "the age of reason based on faith," an age not yet fully spent, left unaltered in its essentials man's fundamental presupposition concerning the functioning of the world and all its contains. There remained a scientific mentality which holds ". . . that all things great and small are conceivable as exemplifications of general principles which reign throughout the natural order" (Whitehead, 1925, p. 13).

The general conception toward which we have been pointing may now be set forth: There has been a long series of attempts through which man sought to lend order to his world and thereby to attribute significance to himself. These, along with the impact of the initial success of physical science (supplying as it did both a demonstration of the scrutability of nature and the model from which subsequent science was developed), left a residue that is still agglutinated to much of the social-scientific enterprise and that continues to have some important and unfortunate consequences. There remains not just the necessary faith in an order of nature, in the sense that events are not random and laws can be discovered, but a general, subtle, culturally inherited habit of thought that the world and each aspect of it are somehow ordered systems and hence to be understood as quasi-closed, mechanical, reactive phenomena—phenomena in which the laws governing change are stable elements of the system itself.

We view the medical model as one of several orientations that share the impact of the same prior assumption. This is seen in the model's acceptance of the notion that personality can be understood as a relatively closed and mechanical system.

The closed-system orientation is akin to nineteenth century naturalism, which generated a scientific imagery wholly dictated by the necessities of classical mechanics. This was a period marked by the tacit belief that whatever question you sought to answer, nature was the test. Whether the subject was ideas, customs, institutions, or the character of man, the answer must obviously be in accord with those laws that nature reveals to all men. It was during this period that the conception of a wholly mechanical world became widely accepted. The twin doctrines of evolution and the dynamics of energy, together with the successful mechanization of biology, physics, and chemistry, contributed to this conception. This was the time of Pasteur's important discoveries, with their implications for the mechanization of medicine; the period usually given for the origin of modern behavior science; and the era during which, in Bruner's (1957) terms, there was a maximum readiness for mechanical explanation in the mental sphere. It was, moreover, the time out of which came the influential works of Sigmund Freud.

It has become commonplace to criticize elements of Freud's theory and to show how certain specific misconceptions, as well as his metaphors and analogies, were natural products of the then existing climate of opinion. In his detailed biography, for example, Jones (1953) points out that although Freud was not consciously influenced by economic theory as he was by physical science, his choice of language, of metaphor, reflecting as it did both of these fields, grew out of the prevailing thought of his time. However, simply to note that Freud borrowed much of his technical language from physical science or to suggest, as Hughes (1958) does, that the vocabulary and analogies so derived were ". . . a convenient path to comprehension on the part of a public steeped in the cult of natural science" (p. 135) overlooks a pertinent question. Were the vocabulary and analogies the only by-products of the intellectual climate of that period, or were there certain presuppositions that may have influenced Freud's acceptance of such analogies as appropriate representations of personality functioning?

It should be emphasized that the influence of Newtonian physics, in combination with other elements in the existing scientific and philosophical milieu, went far beyond provision of terms and metaphors. Such thinking disposed Freud, and others, to a model that henceforth set broad limits on the nature of theorizing in the mental health area.

The basic analogy in Freud's theory of personality is a quantitative analogy of economic distribution, based on the economics of scarcity. Freud constantly referred to the economy of personality, indicating a quantity of energy available for distribution. Basic to his thinking was the libido-fund concept analogous to the wage-fund theory. According to this concept there is a limited amount of psychic energy (or money) available. It can be redistributed, and obstacles to its proper distribution can be removed, but it cannot be enhanced or enriched. The libido-fund theory remains today unaltered in its essentials as an accepted and utilized formulation among many theorists and practitioners.

Freud (1959) expressed his libido-fund, or "libido-quantum," formulation as: "We perceive . . . a certain reciprocity between ego libido and object libido. The more that is absorbed by the one, the more impoverished does the other become" (p. 33). One of the implications of this assumption about personality organization is that object cathexis (i.e., love of, or devotion to, other persons or one's work, duty, etc.) is possible to the extent that the ego is not threatened, for when the self is in jeopardy, energy must be retracted from external matters and directed internally, producing libidinal cathexis. By extending these propositions, it can be seen that effective transaction with the environment, i.e., effective executive ego functioning, depends upon the dynamic or synthetic well-being of the ego.

This supposition of an inherent priority of synthetic over executive ego functioning clearly lies at the heart of much theory and practice in the mental health field. It is a supposition that appears to be implicitly accepted even by those highly critical of psychoanalytic propositions, and one that is quite compatible with the medical model as previously described. This important issue will be discussed in more detail in a subsequent section.

Intimately related to the theory of limited psychic energy is the view that personality develops by the accumulation of compensating devices. Born with a certain set of instincts or drives, the individual is acted upon by internal and external pressures producing tensions and conflicts that impel him to action in order to secure release. Psychoanalysis is thus a consistently dynamic psychology. It begins with force and ends with the dissipation of force, always followed by new forces that must be discharged through tension-reducing processes. Thus the pervading goal of human activity is taken to be homeostasis, i.e., the restoration of the previous equilibrium and not an equilibrium at some other level.

We have attempted to suggest that the antecedents of various aspects of modern mental health theory and practice share a powerful and enduring presupposition about mental functioning. Our contention is that the corollaries of this historically generated orientation amount to an often unrecognized metapsychology that impinges upon and conditions current views and programs.

Perhaps the meaning and impact of this closed-system supposition can be more closely specified by looking at the formulations of Gordon Allport. In evaluating the status of personality theories, Allport (1960) has suggested four criteria of open systems: (1) intake and output of both matter and energy, (2) the achievement and maintenance of steady (homeostatic) states, so that the intrusion of outer energy will not seriously disrupt internal form and order, (3) an increase of order over time, owing to an increase in the complexity and differentiation of parts, and (4) extensive transactional commerce with the environment. While there are probably no personality theories that can be regarded as truly closed systems, current theories differ widely in the amount of openness to which they subscribe. In Allport's (1960) view, ". . . they can be fairly well classified according to the varying emphasis they place upon each of these criteria and according to how many of the criteria they admit" (p. 303).

Most current theories of personality, especially those subscribed to by mental health practitioners, take full account of only the first two requirements of an open system. This is true certainly of psychoanalysis as it is generally of clinical and abnormal psychology. Moreover, conceptualizations of adherents to the medical model, whether or not a psychoanalytic orientation is disclaimed, are necessarily of this order, as are most concepts of social work theory. These theories are thus "biologistic" in the sense that they ascribe to personality only the two features of an open system that are clearly present in all living organisms—they emphasize system stability to the exclusion of other considerations.

Within these accounts of human functioning, behavior is portrayed as an effort to avoid rather than to approach, to compensate for a deficit rather than to seek to realize an aim. In a strictly mechanistic theory of personality, attention to such factors as interest, purpose, curiosity, exploration, language, and the efficacy of instrumental competence is either crowded out or tenuously ordered under an explanatory construct such as secondary reinforcement. Academic developmental psychology, for the most part, does not subscribe to this position. Members of this subfield have for some time been attentive to such factors, regarding them as probably intrinsically motivating elements. However, neither this position nor associated theory and research seem to have had any sizable impact upon the treatment or prevention of mental disorder.

A considerable number of theorists have examined and rejected the supposition of a wholly negative, tension-releasing, compensatory model in favor of a more positive, tension-sustaining view of the individual personality. Emphasis in these theories is upon "the tendency . . . to go beyond steady states and to strive for an enhancement and elaboration of internal order, even at the cost of considerable disequilibrium" (Allport, 1960, p. 305).

In introducing his concept of "competence" and "effectance motivation," White (1959, p. 323, p. 329) has forcefully argued the inadequacies of a strictly compensatory model. He takes the position that ". . . instrumental acts will be learned for the sole reward of engaging in [them] . . . Such activities in the ultimate service of competence must, therefore, be conceived to be motivated in their own right." Subsequently, White (1960, p. 137) amplifies his contention that compensatory models are, in certain respects, inadequate and misleading, noting that they neglect an important range of facts which cannot be slighted if further progress is to be made.

Representing man as striving, seeking, desiring, and willing, Murray (1938, 1951) speaks for an active rather than a passive, until stimulated, view of personality. He stresses (Murray, 1959, p. 18) the concept of progressive disequilibrium, seeing continuity through expansive, constructive change, as a supplement to that of homeostasis. Human beings, in Murray's view, are concerned with more than just the satisfaction of specific needs and a return to some previously established equilibrium. Implied is a sort of proactive directionality in human behavior. Some additional examples of this viewpoint are to be found in Hartmann's (1958) concept of a "conflict-free" portion of the ego, Erikson's (1950, 1959) "search for identity," Anderson and Moore's (1959) "autotelic activities," Hendrick's (1942) "instinct for mastery," and Schilder's (1942) emphasis upon interest, action, and experimentation. Though these theories differ widely in both form and content, each implies acceptance of Allport's (1960) third criterion of open systems: ". . . the tendency of such systems to enhance their degree of order and become something more than at present they are" (p. 305).

The fourth criterion of open systems represents a rather radical departure from conventional conceptions of personality. Historical preference has been to view personality status, and hence, mental health or illness as fundamentally within the individual and, therefore, identifiable independent of the social situation in which he is enmeshed. Not surprisingly then, theories that regard the milieu as an active participant in the personality system have been relatively uninfluential in the mental health field.[1] This view, however, is one which potentially has considerable theoretical import—a point that will be developed in a subsequent section.

It appears to make a considerable difference whether or not personality functioning is conceived in terms of psychic scarcity or whether the system is viewed as open to the world and to new possibility. Most dissenters from the traditional theory, including the present authors, do not question that the compensatory model accurately handles many aspects of personality functioning and development. Our contention is that there are aspects of functioning and development that the model excludes from open consideration. The issue is thus not a matter of a strictly compensatory versus a strictly noncompensatory model or of a wholly mechanical versus a wholly nonmechanical system orientation. What is important is that the nature of one's underlying suppositions determines the types of practices and programs that one is willing to initiate and sets limits upon both theory and investigation.

---

[1] As examples of theorists accepting the fourth criterion, Allport (1960) lists Kurt Lewin, Gardner Murphy, and "role theorists."

THE MEDICAL MODEL IN PRACTICE

As suggested earlier, theories or models are neither true nor false but only more or less useful. Let us look first at the probable utility of the dominant, medical-type models in the domain of community mental health from the standpoint of programs and practices that it generates. In spite of the variable conceptions of the field, one basic starting point of the community mental health emphasis is the recognition that there are a great many persons in the community, particularly among the poor, who exhibit real or potential psychological difficulties. A frequently expressed problem in this connection is that we can never hope to have enough professionals to provide psychotherapy for this vast number of potential clients. As a partial answer to this dilemma, Gordon (1965) has suggested the recruitment of nonprofessionals who could quickly be made available by restricting training to limited and specific techniques. Rioch's program for training mental health counselors, described elsewhere in this volume, is an implementation of this alternative and tends to suggest its feasibility at least on a limited scale. But whether such nonprofessional counselors and therapists can make a sizable impact on the problem depends upon whether the techniques they learn and employ are effective, not simply on their availability.

Are we not still waiting for the first convincing demonstration that uncovering-type therapies work? Is there any compelling reason to believe that, among the disordered, mental status is any more improved over the same period of time in therapy as in the absence of therapy? It is difficult to imagine on what basis we should anticipate that subprofessionals will be more effective than professionals have been. Although community programs will have to rely heavily upon nonprofessional workers, it is clear that, to be effective, these workers will have to fill something other than psychotherapist-type roles. There are a number of instances in which the use of nonprofessionals in a number of roles other than "junior therapist" has been suggested or implemented. See, for example, Reiff and Riessman (1965), Reiff (Ch. 5), and Riessman (Ch. 10). It is of special importance to note that the techniques employed, the associated propositions, and the results observed in such programs cannot be derived from the medical model. Their explanation, as the authors concerned point out, requires a different set of assumptions and hypotheses.

Even if one maintains a faith in the efficacy of psychotherapy as it is currently practiced, communication problems between the therapist and a lower socioeconomic class patient may preclude the success of treatment. After all, many among the poor are characterized by qualities that lead to rejection as untreatable by psychotherapists (Schaffer & Myers, 1954; Rosenthal & Frank, 1958; Brill & Storrow, 1960; Cole, Branch, & Allison, 1962; Hollingshead & Redlich, 1958; Myers, Bean, & Pepper, 1965). Moreover, even in the absence of such professional selectivity, there is good reason to question whether poor individuals will present themselves for therapy or remain in it once begun. Reiff (Ch. 5) has persuasively argued that mental health ideology is so alien to members of the lower classes that they are unlikely to seek or tolerate programs associated with it.

To be successful, a community program must, at a minimum, satisfy the following three requirements: (1) It must effectively promote utilization of services; (2) It must have techniques capable of producing appropriate modification of involved individuals; and (3) It must provide sufficient manpower to achieve full employment of such techniques or services. Programs derived from the medical model are not likely to meet any of these requirements. Thus, although the community programs founded upon traditional mental health views represent an alternative to mere custodial care, they offer little promise of solving the pressing problems of community mental health.

Returning now to our main argument, we have contended that assumptions associated with the medical model have constraining consequences for theory and research as well as for practice. Some of the conceptual difficulties, for which the model is partially responsible, deserve attention.

The Joint Commission on Mental Health, after exhaustive effort to define mental health, finally stated ". . . there is no general agreement on what constitutes mental health or mental illness; mental health means many things to many people . . ." (Ewalt, 1960, p. 10). This state of affairs, of course, has long been indirectly evidenced in the proliferation of both conceptual and operational definitions of mental illness (Scott, 1958) and is more directly evidenced by difficulties in achieving consensus on just what constitutes a psychiatric case (Milbank Memorial Fund, 1953).

Of the major conceptualizations of mental illness the two most frequently used in research are (1) mental illness as exposure to psychiatric treatment, and (2) mental illness as the presence of symptomatology. The first of these can be dispensed with by noting that if the community mental health movement signals nothing else, it certainly signals the demise of the notion that "being in treatment" is a reasonable demarcation between good and poor mental health. Indeed, it was the recognition of the operational and conceptual inadequacies of this view that stimulated some attempts to count all cases of psychological disorders in the community, whether or not treated. By now, it is widely agreed that there are perhaps more people in the community who would be labeled mentally ill than there are patients in mental hospitals.

The criterion of mental illness associated with this revised viewpoint is that of symptomatology or level of pathology, a conceptualization of mental illness that has dominated the thinking of psychiatry and psychology for perhaps the past one hundred years. Indeed, diagnoses and pathology ratings based on the clinical detection of symptoms have always been the ultimate criteria against which other means of identifying and estimating psychiatric disorder are validated. The validity of the psychiatric ratings themselves have most often been assumed to be implicit in the rating process. After all, by definition the physician's opinion *is* the diagnosis, and by convention the only standard against which to test it is another physician's opinion. In other words, the criterion measure for the validity of psychiatric judgment is psychiatric judgment, and therefore any reliability study is, perforce, also a validity study. If one accepts Campbell and Fiske's (1959) view that reliability is measurement by maximally similar means and validity is measurement by maximally different means, it must be concluded that this is all a very peculiar set of concepts and procedures. It is an instance in which standard social science technology has been forsaken in favor of classic medical orthodoxy.

It seems unnecessary to document the difficulty that has been encountered in achieving reliability in psychiatric ratings (and therefore, of achieving adequate validity) since that difficulty is, by now, recognized to be notorious. There have been some instances in which psychiatric ratings have been compared with outside criteria such as performance, hospitalization, or peer ratings, thereby allowing a different sort of validity estimate. In such cases the amount of variance in performance, outcome, or present treatment status which has been accounted for by degree of pathology has been noteworthy only by its smallness.[2]

The inability of judged pathology to account for differences in factors such as adequacy of performance and other factors that are integral parts of mental status poses some interesting and vital questions. Is it that psychopathology ratings are insensitive or incomplete as a description of the intrapsychic status of the individual, or is it that social factors cause the unexplained variations? In spite of the recent vogue to select social variables for special study, it is proposed that both alternatives may be true.

It is not new to contend that degree of manifest pathology is inadequate as a singular representative of mental status or that positive factors such as skills, strengths, and successful patterned instrumental response mechanisms are the ingredients that need to be added. Not many would deny that, in a practical as well as in a theoretical sense, mental health *is* personality somehow evaluated. And few would suggest that any reasonable evaluation of "personality" could consider only those mechanisms regarded as pathological. If these points are so generally accepted, why have we made so little progress? Why does pathology, in practice, remain a focus that crowds from attention the issue of positive elements? Our suggestion is that the explanation lies in the pervading tendency to regard strengths and weaknesses as reciprocals. Such a view effectively dilutes any tension to achieve measures of positive elements with the recognition that the inverse of any factor is automatically and necessarily contained in the measurement of that factor. Since measures or judgments of pathology seem easier to achieve and because many procedures and indices are already available, pathology, in our research, remains a primary and essentially exclusive focus. It may be time to challenge this unsupported and long-standing habit of regarding strengths and weaknesses as highly and negatively correlated and open the question of their relationships and the contributions of each to what we intuitively mean when we speak of mental status or mental health.

---

[2] One case in point is psychiatrists' gross inability during World War II to predict military performance as evidenced by the lack of relationship between strictness of screening procedures and subsequent rates of separation on psychiatric grounds (Ginzberg, Anderson, Ginsburg, & Herma, 1959). A similar finding is reported by Raines and Rohmer (1955). In one of our studies in collaboration with the University of Rochester Department of Psychiatry (not yet reported) the pathology ratings of 214 randomly selected schizophrenics accounted for less than 10% of the variance in time spent in the hospital.

The foregoing discussion suggests that the solutions to community mental health problems do not lie simply in the tactic of increasing the availability of current psychotherapeutic techniques. Similarly, the related problem of adequately defining our object of study is not likely to be solved by the simple expedient of achieving consensus. Whichever major extant definition may be selected, it is likely to fail, in important ways, to encompass all of what we view as mental illness or to distinguish groups whose status or performance varies significantly.

While continued empirical research is needed and may very well assist us in our conceptualizing and defining problem, our argument is that present orientations and definitions are primarily expressions of theoretical predilection. The problem, therefore, is more a matter of theory than of empirical fact.

AN ALTERNATIVE FRAME OF REFERENCE

The formulation that follows begins with a specific confrontation of one of the major presuppositions of medical-type models and provides suggestions as to the type of propositions that could follow from a revision. It will be contended that the dominant tendency to focus almost exclusively upon symptomatology derives primarily from a tacit assumption of the pervading priority of the synthetic functions of the ego as discussed earlier. This assumption is challengeable on a purely conceptual basis as well as on the grounds that it has led us away from an explication of the ways in which an individual, operating in a complex environment, becomes a healthy, successful person. In addition, the need to face the problem of relating mental status to the individual's ability to resist disorganization under stress has, no doubt, been blurred by the force of this questionable assumption.

Earlier it was noted that the criticisms of Freud did not apply with equal force to all psychoanalysts. Those exceptions are pertinent here. The term *ego psychology* is used to designate what is now a fairly widespread movement among contemporary psychoanalysts and psychiatrists to emphasize the role and importance of the ego, not only as a synthesizing agent but as a controller of a wider range of processes and behaviors. Ego psychology depicts the ego as rational and as responsible for intellectual and social achievements. The ego is not solely dependent upon the id, since it has its own source of energy, its own motives, and its own objectives.

As an important theoretical force, ego psychology perhaps began with Hartmann's (1939) postulation of a conflict-free portion of the ego. Underlying this idea was the hypothesis that there is intrinsic energy behind ego development and that, in this sphere, growth yields a pleasure all its own. Having observed the regularity of the development of children's speech and motility, Hartmann concluded that the instrumental ego functions must emerge, not through id-superego conflict but through maturation and the effects of the environment, in a process similar to overt learning.

This formulation, later elaborated by other ego psychologists, revised Freud's libido-quantum theory and, along with it, the singular focus upon psychopathology. While workers such as Erikson (1950, 1959), White (1959, 1960), and Anderson and Moore (1959) have lent considerable support to the idea of a relatively independent executive domain, the implications of this view for theory and research have never been fully drawn out. If the bases of the executive and synthetic functions of the ego are indeed independent of each other, the customary notion that effective executive function is a *consequence* of the well being of the synthetic function may not be wholly accurate. There seems, in fact, no theoretical reason why the reverse may not be equally true, or why synthetic functioning, expressed in terms of adequacy of defense systems, is any more vital to a description of personality than is executive function, expressed in terms of skills or strengths.

This view can be summarized into three premises:

1. That skills are to the executive portion of the ego what defense mechanisms are to the synthetic portion (Cumming, 1963; Cumming & Cumming, 1962).
2. That even though the two are doubtless intertwined in complex behavior, the synthetic and executive functions of the ego can be productively regarded as separate, and in some respects independent.
3. That to the extent that there is a degree of dependence between these domains, such dependence is bilateral rather than unilateral.

Favorable considerations of the proposed shift in underlying suppositions carries with it two immediate implications:

1. That we accept, as a hypothesis, the notion that mental health can be modified by paying attention primarily to the executive domain

of ego functioning. This is implicit as an assumption within aspects of the "war on poverty" and is apparently accepted by several contributors to the present volume (Reiff, Ch. 5; Riessman, Ch. 10; Klein, Ch. 9).

2. That we modify the range of behaviors we are willing to admit as relevant to mental health. What must be added are those data that can provide an index of executive functioning.

In an article entitled "The Inadequacy Syndrome," Cumming (1963) has pointed out that ". . . we have . . . in the past restricted the types of behavior that we are willing to call symptoms. It has been usual to conceive of such symptoms as auditory hallucinations as evidence of disease, while thinking of phenomena such as the inability to hold a job as the *results* of illness" (p. 723). He contends that it is important to realize ". . . that both these behaviors are evidence of ego failure and can equally be called symptoms of mental illness" (p. 723).

Many investigators (McCaffrey, Cumming, & Rudolph, 1963; Davis, Freeman, & Simmons, 1957; Monck, 1963; Harrington & Wilkins, 1966) have reported a decidedly disproportionate number of occupationally inadequate people among those defined as mentally ill, suggesting a relationship between mental illness and work failure. Such findings leave open the question of whether work failure is a result of illness or a relatively independent index of illness. If inability to hold a job results from illness, severity of symptoms and work performance should be highly correlated. Among studies that have included some estimate of severity of illness, no impressive relationship has been shown between level of pathology and current or long-term work performance (Brown, Carstairs, & Topping, 1958; Freeman & Simmons, 1963), adding support to the argument that both executive and synthetic functions must be considered in treatment as well as in personality evaluation.

There seems much to suggest that we might do very well, both in prevention and treatment, to recognize social "symptoms" of ego failure and to work directly on enhancing executive functioning, rather than to continue in the belief that if we could just learn to uncover and remove the pathogenic sources of symptoms, the individual would become a more effective, instrumentally competent human being. It may even be reasonable to hypothesize that enhancement of executive functioning may affect synthetic processes, producing a reduction in symptomatology.

Before moving ahead, two points warrant explicit reemphasis. First, it is not our contention that mechanistic or homeostatic principles are unimportant, but rather that they are insufficient. We do not wish to do away with the concept of tension reduction; our call is for more serious attention to those factors in development and functioning that go beyond or fall outside such principles. Second, this view is not particularly radical and is being expressed by an increasingly large number of professionals concerned with mental health problems. Such attention, unfortunately, has produced little observable impact upon research or programs of prevention or rehabilitation. In practice, the quasi-closed personality model remains the dominant basis upon which theories, training of professionals, and the development of techniques are based. Such models remain, therefore, an important guiding and constraining force.

SOME ADDITIONAL HYPOTHESES AND IMPLICATIONS

We have, up to now, called attention to certain alternative suppositions that suggest directions for theory and inquiry which are somewhat divergent from traditional and well-worn paths. The development of such a revised frame of reference requires specification of processes or mechanisms by which executive competence is produced and comes to be differentially distributed in the population. While such a task cannot be undertaken in detail here, three additional and interrelated hypotheses relevant to community mental health programs will be treated briefly.

CRISIS OR PROBLEM RESOLUTION IS A PRIMARY FACTOR IN EGO DEVELOPMENT AND MODIFICATION

Erik Erikson (1950, 1959) has conceptualized personality growth as occurring through the resolution of normative or developmental crises. The stages or phases differentiated by Erikson are seen as systematically interrelated, each depending upon the proper solution of those preceeding.[3] Only those who have successfully resolved the problems or crises of previous phases are likely to achieve a lasting solution to the present stage, since subjective achievements derived from previous solutions are seen as building blocks for present and future solutions. The position is thus consistent with the common observation that success begets success.

Erikson's formulation emphasizes the individual's constant and active intercourse with the environment as crucial for development. Problems are encountered and, with varying degrees of success, resolved. The individual emerges from such engagements with new skills which are added to his repertoire of generalizable response mechanisms, thereby increasing the probability that future encounters will be successfully handled. This developmental process, therefore, involves, in addition to a synthesizing of new experiences into a continually evolving self-perception, the direct accumulation of an armamentarium for instrumental response.

[3] Erikson discriminates a total of eight stages or phases of development. Though he invests much in the designation and description of these stages, it should be noted that their contents are not crucial to the basic conception of personality growth through crises resolution which is to be discussed. In short, it is quite possible to accept the principle that solutions of crisis encounters have profound effects upon personality development without accepting the substantive content of the stages described.

The primary organizational construct in Erikson's theory is "ego identity." This concept has been interpreted by Turner (1963) as a collective representation of the significant components and evaluations derived from experience. As such, it is seen as encompassing one's repertoire of roles and segmental identities, the skills, abilities, and specific instrumental response mechanisms related thereto, and the more general response tendencies related to the collective whole. Ego identity, therefore, is directly enhanced by successful crisis resolution, gaining proven behavioral sets and adding to the store of subject-object relatedness that allows increasingly abstract functioning. Identity is thus seen as including those elements of executive functioning that we have referred to as ego competence.

Erikson contends that developmental and normative crises differ from imposed or traumatic crises in that the growth process provides new energy for their solutions. Since, however, non-normative crises are frequently experienced, with a variety of outcomes, it seems reasonable to propose that: (1) such events, when *successfully resolved,* also promote ego growth and hence mental health, and when unresolved are detrimental, and (2) crises remain both problems and opportunities far beyond the attainment of adulthood.

The above proposal is not without some empirical support. Indeed, generalizations such as the degree of stress suffered by an individual when confronted by new and difficult situations depends upon the amount of success experienced in previous new and difficult situations—or that competence begets competence—are so widely expressed that little documentation seems necessary. It has been observed, for example, that: (1) combat troops and civilian populations under repeated stress make increasingly effective adaptations (Janis, 1951), (2) past performance predicts future performance (Lecky, 1951), (3) a person who has demonstrated ability to cope with crises is likely to perform well in disaster (Perry, Silber, & Bloch, 1956), and (4) the experience of disaster helps equip populations to handle extreme situations better (Beach & Lucas, 1960). The logical implication of these, as well as other, observations and research findings has been expressed by Wilson (1962). He states that ". . . research has demonstrated repeatedly that disaster is not necessarily and in all ways damaging to either individual health or social organizations and . . . may indeed have curiously beneficial implications . . ." (p. 131).

Caplan (1961) and his colleagues have proposed a process of "therapeutic intervention" that is implicitly related to this proposition. Klein and Lindemann (1961, p. 286, p. 305), for example, conclude, in reference to therapeutic intervention, that beyond the goal of restoring the equilibrium existing prior to the crisis ". . . is the opportunity in some cases to foster a more desirable equilibrium between an individual and his immediate human environment. . . . Thus, it is clear that hazards provide opportunities for promotion of emotional growth as well as the occasions for preventive measures." Similarly, Cumming and Cumming (1962) have taken the position that the opportunity to deal effectively with a series of crises of graded difficulty will produce ego growth and integration. Based upon this view, they have formulated a therapeutic system of induced crisis and controlled environment that is presumed to be applicable to the whole array of mental illnesses.

The belief that attending primarily to the executive domain of ego functioning may be an avenue to personality modification seems of crucial importance for community mental health planning. Given this position, the burdensome task of routinely accomplishing diagnostic classification, in the hope of somehow providing differential treatment, could be relinquished. Moreover, it would allow a consistent treatment approach within the relevant and meaningful context of assisting individuals in the solution of their own problems (and program-generated problems) and in developing more successful actions and coping techniques.

Before proceeding further, it should be made clear that the term *crisis* is being used here in a very broad sense to refer to any event, whether developmental or normative, imposed or traumatic, that places in question the individual's view of himself, of his environment, or both. We, therefore, understand crises to be personal experiences rather than objective social or physical occurrences. Whether a given event constitutes a crisis depends upon its meaning to the individual in terms of his real or perceived ability to handle it emotionally and practically. As White (1963) points out, "Threat is not solely a quality of the stimulus; it lies rather in the relationship between the stimulus and our ability to deal with it" (p. 138).

A VITAL COROLLARY TO THE EXPERIENCE OF CRISES IS A HEIGHTENED OPENNESS TO ENVIRONMENTAL INFLUENCE

Erikson (1950, 1959) has contended that each new psychosocial development carries with it its own specific vulnerability and it is through such vulnerability that the training agents of society are most effective. While Erikson specifically uses the term *vulnerability* to characterize the individual's state during crisis, he seems to be referring to a kind of openness to both harm and enhancement. This is evidenced in his view that ego growth occurs through the resolution of phase-specific crises and hence that the disequilibria that characterize these crises offer potential for forward developmental leaps as well as for ego damage. Following Erikson, it is assumed that all crises are characterized by vulnerability or "openness."

This assumption is of considerable theoretical importance and practical consequence. It is a major proposition in the theory of Cumming and Cumming (1962) and is, implicitly, one basis for the "therapeutic intervention" scheme described by Klein and Lindemann (1961). Its tenability is further supported by many research studies, including those concerned with reaction to natural disasters. Illustratively, the generalization that "In the absence of reliable guidance from past experience for perceiving or acting, suggestibility is high," first suggested by Cantril (1941), has been applied by Kilpatrick (1957, p. 21) in relation to crisis situations. Kilpatrick observes that much experimental work has demonstrated its validity.

Glass (1955) thinks "suggestibility"—a form of openness—is a primary characteristic of soldiers who break down in the face of acute combat stress. During World War II, the occurrence of suggestibility among "combat exhaustion" casualties led to the formulation of a new therapy system centered on the concept of "expectancy" (American Psychiatric Association, 1956). According to Glass (1955), "Military experience has demonstrated that situationally induced . . . disorders worsen or improve, depending upon what is expected of the patients by persons responsible for their treatment and disposition" (p. 12). Nonverbal attitudes and actions were found to be far more effective than words in communicating such expectations. The success of this expectancy-centered therapy as compared to conventional psychotherapy led to the institutionalization of these procedures in treating victims of both combat exhaustion and large-scale disaster and argues forcefully for the proposition stated above.

The principle that the disequilibria of crises carry a heightened openness to environmental influence suggests, on the one hand, a mechanism for the conduct of programs for ego modification, and, on the other, the importance of timely intervention with persons who are facing severe events. For programs that take seriously the need to provide assistance and treatment to the poor, this latter point may be particularly crucial.

Dohrenwend and Dohrenwend (1965) have suggested that the observed high level of symptomatology in the lowest socioeconomic stratum may represent transient responses of individuals to objective, stress-producing events in the immediate environment (see also Dohrenwend, 1961; Tyhurst, 1957). Underlying this view are observations that normal individuals exposed to severe circumstances often respond with symptoms that would ordinarily be classified as psychopathological (Hastings, 1944; Janis, 1951; Lindemann, 1944; Fried, 1963) and evidence suggesting the relative pervasiveness of "stressors" in the lower-class environment. These stressors include such things as shorter life expectancy (Mayer & Hauser, 1950), unemployment and threat of unemployment (Hollingshead, 1947; Langner & Michael, 1963), problems of relocation (Fried, 1963), and the general degree of economic and social deprivation.

If the expected frequency of crisis experiences is high among low socioeconomic status individuals and if the two hypotheses stated above are legitimate, several conclusions regarding possible directions for community mental health programs follow. The first is that programs with a major commitment to providing knowledge, skills, and experience in crisis resolution offer a promising alternative to conventional treatment approaches. Such programs must be prepared to turn difficulty into advantage by utilizing ongoing problems as bases for growth-producing experiences for involved individuals and, where such raw material is insufficient, to provide relevant problem situations.

Since crises provide both hazards and opportunities, the program must be capable of minimizing hazards and maximizing opportunities. This requires sufficient problem screening, problem structuring, and guidance to insure some success in resolution. For it is successful problem solutions that are presumed to result in ego growth and to contribute to the vital perception that one can, through his own efforts, have an effect upon his environment. In addition, the program requires avoidance and even rebuttal of sickness or mental problem labels for experienced difficulties. Given the corollary to crisis of heightened openness to environmental suggestion, such labels are likely to be deeply internalized and, as Glass (1955) has shown, to have important and enduring regressive effects. Based upon the foregoing consideration and because utilization by low socioeconomic groups may depend upon it, the structure of such a program should preclude the assumption that a person must be mentally ill in order to receive assistance. To take advantage of the openness inherent in natural or program-generated disequilibria, a program must effectively transmit an expectation that the individual can, or will be able to, cope with, adjust to, and effectively approach, life problems.

PERSONALITY FUNCTIONING IS SUBSTANTIALLY DEPENDENT UPON THE CHARACTER OF THE RELEVANT SOCIAL MILIEU

The hypothesis of heightened openness to influence as a characteristic of crisis experiences suggests one circumstance in which personality functioning may be closely dependent upon the environment. It is proposed that such dependence, although variable across both individuals and situations, is not restricted to severe circumstances, but is a general and continuous phenomenon. In describing his concept of ego identity, Erikson (1950, 1959) includes three elements: the definition of the self, the state of congruence between the self and the requirements of the environment, and the expectation that this congruence will continue. In this view the stability of the personality system depends upon environmental feedback. Experimental and clinical evidence that the sense of self and level of functioning are dependent upon continued external confirmation supports this concept. Hebb (1955), for example, has interpreted sensory deprivation experiments as demonstrations of the constant dependence of inner stability on the flow of environmental stimulation, and Heron (1961) has concluded that such deprivation interferes with cognitive functions. The maintenance of one's identity is thus seen as requiring continued reinforcement of the nature and appropriateness of its roles, skills, and abilities. All parts of the environment, the physical, the interpersonal, and the social-organizational, are involved in this process of ego reinforcement. If self-definition, including status, abilities, and roles, through which problems are solved, is not maintained, the individual may feel he no longer possesses such capacities and thus may be unable to make the adaptive responses of which he is capable.

The importance of the milieu cannot be overemphasized. In daily interaction with the environment, the individual not only learns new concepts and skills, but also receives new proofs of already achieved, cherished abilities and of continuing areas of ineptness. The environment, then, must be regarded as an inextricable partner in the identity system. In addition, it provides the framework for carrying out actions, defines the paths open for solution of problems, and determines whether or not group support will be forthcoming. Following Allport (1960), we thus accept with caution the fourth criterion of open personality systems—that of extensive transactional commerce with the environment.

It follows from this proposition that personality and social structure cannot ever be regarded as wholly independent. We do not deny that, for many purposes, personal adequacy and social factors can be treated as though they were independent variables. Our view is simply that when dealing with such dependent variables as responses to stress, solution of problems, adjustment to hardship or disability, or even ego disorganization, it is necessary to consider the intimate relationship between personality functioning and the social milieu.

The hypotheses presented above are examples of propositions that are derivable from the suggested revision of basic assumptions about the nature of mental health. It is a separate question whether these alternative directions will better serve community mental health needs. We believe that this question can tentatively be answered in the affirmative. There seems good reason to anticipate: (1) that programs and techniques based on these conceptual revisions may be effective in prevention and in personality modification, (2) that these will better lend themselves to the extensive utilization of nonprofessional workers, and (3) that their "face validity" is likely to encourage rather than discourage participation by the poor.

REFERENCES

Allport, G. W. The open system in personality theory. *J. abnorm. soc. Psychol.*, 1960, *61*, 301-309.

American Psychiatric Association, Committee on Civil Defense. *Disaster fatigue.* 1956, NAVMED P-5051.

Anderson, A. R., & Moore, O. K. *Autotelic folk models.* New Haven, Conn.: ONR Technical Report, 1959.

Beach, H. D., & Lucas, R. A. (Eds.) *Individual and group behavior in a coal* *mine disaster*. Washington, D.C.: National Academy of Sciences—National Research Council, 1960, Disaster Study No. 13.

Brill, N. Q., & Storrow, H. A. Social class and psychiatric treatment. *Arch. gen. Psychiat.*, 1960, 3, 340-344.

Brown, G. W., Carstairs, G. M., & Topping, G. G. The post-hospital adjustment of chronic mental patients. *The Lancet*, 1958, *ii*, 685-689.

Bruner, J. S. Freud and the image of man. In B. Nelson (Ed.), *Freud and the twentieth century*. Cleveland: World Publishing, 1957, Pp. 277-287.

Campbell, D. T., & Fiske, D. W. Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychol. Bull.*, 1959, *56*, 81-105.

Cantril, H. *The psychology of social movements*. New York: Wiley, 1941.

Caplan, G. (Ed.) *Prevention of mental disorders in children*. New York: Basic Books, 1961.

Cole, N. J., Branch, C. H. H., & Allison, R. B. Some relationships between social class and the practice of dynamic psychotherapy. *Amer. J. Psychiat.*, 1962, *118*, 1004-1012.

Cumming, J. The inadequacy syndrome. *Psychiat. Quart.*, 1963, *37*, 723-733.

Cumming, J., & Cumming, E. *Ego and milieu*. New York: Atherton Press, 1962.

Davis, J., Freeman, H., & Simmons, O. G. Rehospitalization and performance level among former mental patients. *Social Problems*, 1957, *5*, 37-44.

Dohrenwend, B. P. The social psychological nature of stress: A framework for causal inquiry. *J. abnorm. soc. Psychol.*, 1961, *62*, 294-302.

Dohrenwend, B. P., & Dohrenwend, B. S. The problem of validity in field studies of psychological disorder. *J. abnorm. Psychol.*, 1965, *70*, 52-69.

Erikson, E. H. *Childhood and society*. New York: Norton, 1950.

Erikson, E. H. Identity and the life cycle. *Psychol. Issues*, 1959, *1*, No. 1.

Ewalt, J. R. In introduction to G. Gurin, J. Veroff, & S. Feld, *Americans view their mental health*. New York: Basic Books, 1960, Pp. 9-26.

Freeman, H. E., & Simmons, O. G. *The mental patient comes home*. New York: Wiley, 1963.

Freud, S. On narcissism: an introduction. In *Collected papers* Vol. IV. New York: Basic Books, 1959, Pp. 30-59.

Fried, M. Grieving for a lost home. In L. J. Duhl (Ed.), *The urban condition*. New York: Basic Books, 1963, Pp. 151-171.

Ginzberg, E., Anderson, J. K., Ginsburg, S. W., & Herma, J. L. *The lost divisions*. New York: Columbia, 1959.

Glass, A. J. Psychotherapy in the combat zone. In *Symposium on stress*. Washington, D.C.: Army Medical Service Graduate School, 1953.

Glass, A. J. *Psychological consideration in atomic warfare*. Washington, D.C.: Army Medical Service Graduate School, 1955, No. 560.

Gordon, J. Project cause: The federal anti-poverty program and some implications of sub-professional training. *Amer. Psychol.*, 1965, *20*, 334-343.

Harrington, C., & Wilkins, M. L. Treating the social symptoms of mental illness. *Hosp. & comm. Psychiat.*, 1966, *17*, 136-139.

Hartmann, H. *Ego psychology and the problem of adaptation*. Translated by David Rapaport. New York: International Universities Press, 1958. Originally published in German in 1939.

Hastings, D. W. Psychiatry in eighth air force. *Air Surgeon's Bulletin,* 1944, *1,* 4-5.

Hebb, D. O. The mammal and his environment. *Amer. J. Psychiat.,* 1955, *111,* 826-831.

Hendrick, I. Instinct and the ego during infancy. *Psychoanal. Quart.,* 1942, *11,* 33-58.

Heron, W. Cognitive and physiological effects of perceptual isolation. In P. Solomon, P. E. Kubzansky, P. H. Leiderman, J. H. Mendelson, R. Trumble, & D. Wexler, *Sensory deprivation.* Cambridge, Mass.: Harvard, 1961, Pp. 6-33.

Hollingshead, A. B. Selected characteristics of classes in a middle western community. *Amer. soc. Rev.,* 1947, *12,* 385-395.

Hollingshead, A. B., & Redlich, F. C. *Social class and mental illness.* New York: Wiley, 1958.

Hughes, H. S. *Consciousness and society.* New York: Random House, 1958.

Janis, I. L. *Air war and emotional stress: Psychological studies of bombing and civil defense.* New York: McGraw-Hill, 1951.

Jones, E. *The life and work of Sigmund Freud.* New York: Basic Books, 1953.

Kilpatrick, F. P. Problems of perception in extreme situations, *Hum. Org.,* 1957, *16,* 20-22.

Klein, D. C., & Lindemann, E. Preventive intervention in individual and family crisis situations. In G. Caplan (Ed.), *Prevention of mental disorders in children.* New York: Basic Books, 1961, Pp. 283-306.

Langner, T. S., & Michael, S. T. *Life stress and mental health.* New York: Free Press, 1963.

Lecky, P. *Self-consistency.* New York: Island Press, 1951.

Lindemann, E. Symptomatology and management of acute grief. *Amer. J. Psychiat.,* 1944, *101,* 141-148.

McCaffrey, I., Cumming, E. & Rudolph, C. Mental disorders in socially defined populations. *Amer. J. pub. Health,* 1963, *53,* 1025-1030.

Mayer, A. J., & Hauser, P. Class differentials in expectation of life at birth. *Rev. Inst. of Internat. Stat.,* 1950, *18,* 197-200.

Milbank Memorial Fund. Definition of a case for purposes of research in social psychiatry. In *Interrelations between the social environment and psychiatric disorders.* New York: Author, 1953.

Monck, E. M. Employment experiences of 127 discharged schizophrenic men in London. *Brit. J. prev. & soc. Med.,* 1963, *17,* 101-110.

Murray, H. A. *Exploration in personality.* New York: Oxford University Press, 1938.

Murray, H. A. Toward a classification of interaction. In T. Parsons & E. A. Shils (Eds.), *Toward a general theory of action.* Cambridge, Mass.: Harvard, 1951, Pp. 434-464.

Murray, H. A. Preparations for the scaffold of a comprehensive system. In S. Koch (Ed.), *Psychology: A study of a science.* Vol. III. New York: McGraw-Hill, 1959, Pp. 7-54.

Myers, J. K., Bean, L. L., & Pepper, M. P. Social class and psychiatric disorders: A ten year follow-up. *J. health & hum. Beh.,* 1965, *6,* 74-79.

Perry, S. E., Silber, E., & Bloch, D. A. The child and his family in disaster: A study of the 1953 Vicksburg tornado. *Nat. Acad. Sci: Nat. Res. Coun. Publ.,* 1956, No. 393.

Raines, G. N., & Rohmer, J. H. The operational matrix of psychiatric practice 1: Consistency and variability in interview impressions of different psychiattrists. *Amer. J. Psychiat.,* 1955, *91,* 721-733.

Reiff, R., & Riessman, F. The indigenous nonprofessional. *Community Ment. Hlth. J. Monographs,* 1965, Monograph No. 1.

Rosenthal, D., & Frank, J. D. The fate of psychiatric clinic outpatients assigned to psychotherapy. *J. nerv. ment. Dis.,* 1958, *127,* 330-343.

Schaffer, L., & Myers, J. K. Psychotherapy and social stratification, *Psychiatry,* 1954, *17,* 83-93.

Scheff, T. J. The role of the mentally ill and the dynamics of mental disorder. *Sociometry,* 1963, *26,* 436-453.

Schilder, P. *Goals and desires of man: A psychological survey of life.* New York: Columbia, 1942.

Scott, W. A. Research definitions of mental health and mental illness. *Psychol. Bull.,* 1958, *55,* 29-45.

Szasz, T. *The myth of mental illness.* New York: Hoeber-Harper, 1961.

Turner, R. J. *Social structure and crisis: A study of the effects of differing organizations of nursing services upon the adjustment of hospital patients.* Syracuse, N.Y.: Mental Health Research Unit, N.Y. State Dept. of Mental Hygiene, 1963.

Tyhurst, J. S. The role of transition states—including disasters—in mental illness. In *Symposium on preventive and social psychiatry.* Washington, D.C.: Walter Reed Army Institute of Research, 1957, Pp. 15-17.

White, R. W. Motivation reconsidered: The concept of competence. *Psychol. Rev.,* 1959, *66,* 297-333.

White, R. W. Competence and psychological stages. *Nebraska Symposium on Motivation.* Lincoln: University of Nebraska Press, 1960, Pp. 97-139.

White, R. W. Ego and reality of psychoanalytic theory. *Psychol. Issues,* 1963, 3, 1-210.

Whitehead, A. N. *Science and the modern world.* New York: Macmillan, 1925.

Wilson, R. N. Disaster and mental health. In G. W. Baker & D. W. Chapman (Eds.), *Man and society in disaster.* New York: Basic Books, 1962. Pp. 124-150.

4

THE RELATION OF CONCEPTUAL MODELS TO MANPOWER NEEDS[1]

George W. Albee

Western Reserve University

A day of reckoning is coming!

The manpower demands projected over the next twenty years in the fields concerned with professional care for people with emotional disorder are so far beyond the probable supply of people available as to constitute a major national crisis (Albee, 1965).

For years there has been a double standard of care for people with behavioral and emotional disorders in this country, one for the rich and one for the poor. The chasm between private care and public care has been growing steadily deeper, and the quality gap has continued to widen. For years we have talked about the need for expanding our professional training programs, but demand is expanding much more rapidly than the output of professional people from our training centers. We have talked about the need for training subprofessional people to supplement the efforts of members of the mental health professions, but we have not really begun to train such people. We have talked about using qualified members of any mental health profession to provide administrative leadership and broad-ranging service, but when the laws are written and the regulations are drafted, the powerful lobbies of vested-interest groups—especially the medical groups—are always there to insist on the illness model and on medical control.

The time is not far off when the whole mental health bubble bursts! We have made irresponsible promises to the people, to Congress, to the state legislatures, and to the labor unions. We will *not* be able to deliver adequate and meaningful services.

---

[1] Sections of this chapter were presented as part of an all-day Workshop on Unions and Mental Health sponsored by the Chicago Area Workers' Mental Health Plan and the Labor Education Division of Roosevelt University at the annual meeting of the American Orthopsychiatric Association in San Francisco in April, 1966. Other sections of the chapter, in somewhat different form, were written in response to a request from the California Medical Educational and Research Foundation for a paper for distribution in conjunction with their State Mental Health Planning Project in California. Parts of the chapter were also read at a meeting of the New York State Psychological Association's Annual Meeting at the Statler Hilton in New York City in May, 1966. In each instance, a Proceedings report is planned which may contain excerpts of this material for fairly limited distribution.

Our inability to provide service will derive largely from the defects in the conceptual model that dictates the kinds of manpower required. Much useful and effective intervention with emotionally disturbed children and adults could be done by people with bachelor degrees (or with even less education), who are in potentially large supply. But exploration of these routes is blocked by our present model.

Let us look first at the kinds of demands that are developing, then at the professional resources available to meet them, and finally at the need for alternative models for intervention that could change the strategy of manpower utilization.

We are told that currently more than half of all first admissions for mental disorders are to psychiatric units in general hospitals. But still the overwhelming majority of mental hospital beds are in tax-supported public mental hospitals. How is this magic feat accomplished? It is accomplished by admitting a growing number of people to the small psychiatric units in general hospitals because they have hospitalization insurance to cover the high cost of such hospitalization. They receive intensive treatment there and then move out. If their symptoms are still too severe to prevent their being discharged after their hospitalization insurance runs out, they are transferred for "continuing care" to the public mental hospital. They are not then considered first admissions, but transfers, although this is purely a verbal game.

In the past two decades more people, from the blue-collar group to the upper class, have acquired hospital insurance coverage. This has resulted in strong demands for expansion of psychiatric facilities in general hospitals. It has also drawn precious professional mental health manpower into these general hospitals, further depleting the thin ranks available in public tax-supported mental hospitals. It has also cut into time available for private office practice.

But this is only the beginning!

The anticipated demands of the new Comprehensive Community Mental Health Centers themselves could use up the available supply of professional people. Added to these are current and pending demands for augmented programs in mental retardation, in alcoholism, in drug addiction, in the emotional problems of children in schools, in the whole range of the poverty programs, in juvenile delinquency, etc. Alcoholism, for an example, now seems destined to be labeled a disease (by the courts) requiring treatment rather than punishment. But how will five million alcoholics be treated, and by whom?

Any of these expanding programs may serve as an example of the flavor of the unprecedented developing demand. Much of the demand is for psychiatric care, so specified, and all of the programs accept without question the illness model of mental disorder. One example is the United Auto

Workers contract for the insurance coverage, for private outpatient psychiatric care, of its members and families, totaling close to two million people. Other unions are moving in the same direction; still others have begun to establish their own mental health clinics for their members and families. The extension of benefits to cover emotional disorders in union members and their families has been announced by the labor press with a flurry and a fanfare. But where are the professionals who are going to provide either the private outpatient care or the union clinic care?

Written into the first type of insurance contract is a requirement that the outpatient services be provided by a physician, preferably a psychiatrist, or by someone working under the direct supervision of a physician. While this apparent step backwards in interprofessional tolerance rankles psychologists and social workers providing psychotherapy in the community, numerically the total of professional groups available to provide these services is so small as to make relatively little difference anyway, realistically. How many psychiatrists are there today in Flint, or Pontiac, Michigan?

This new outpatient coverage can only have the effect of increasing the demands on professional time. But are there any psychiatrists in any major city with blocks of free time in their appointment schedules? They have already reached the limit in terms of the number of hours a week they are able to work. So where does the increased demand find increased supply of outpatient time? If 1 per cent (the Union's best estimate) of those covered by the union contracts seek care each year, we have increased demand by 20,000 cases, from the UAW alone, in geographic areas where there are few competent psychiatrist-psychotherapists.

Another example. The most important single legislative act in the whole care field is the Medicare bill. Under provisions of Medicare one of the largest single groups of potential new users of mental health professional time has suddenly been umbrellaed in for prepaid service.

There are several provisions in the Medicare bill which will increase demands on all of the mental health professions, but especially on psychiatry. One of these is the new assurance of outpatient psychiatric care for the over-sixty-five person. It seems reasonable to anticipate that older persons, paying their monthly premiums (which entitle them to these outpatient psychotherapeutic services on a matching basis), will have plenty of spokesmen in Congress ready to investigate their complaints about the unavailability of such services. It also seems sure that the new coverage for hospitalization for mental disorders of older people will swamp available psychiatric beds in general hospitals.

But the most important component of the Medicare bill is Title 19. This section, which may turn out to be the biggest manpower sleeper of all time in this field, provides for a wide range of mental health and rehabilitative services for all persons adjudged "medically indigent," and what is more, for their children up to age nineteen. The language of the law here is sufficiently general as to include many services provided primarily by members of the mental health professions. Not only is psychotherapy included but also counseling, vocational guidance, and many forms of remedial training, including special education.

When the manpower demands on psychiatry for satisfying the requirements of Medicare are added to those required for establishing labor union consultation centers for the prepaid provision of mental health care for blue-collar workers, plus the new insurance for outpatient psychiatric care for union members (as typified by the Auto Workers plan), plus the demands for people to staff the new Comprehensive Mental Health Centers, etc., we arrive in a Never-Never Land of promises without personnel.

So the day of reckoning is coming! All of the plans for augmented mental health care—care for the union member, for the blue-collar worker, for the medically indigent, for the whole variety of special groups in our society on whom the spotlight of public attention is now focused—all of these programs are foredoomed to failure because of the unavailability of the kind of medical and paramedical professional resources demanded by the illness model and the bankruptcy of our conceptual models generally in this field.

The mental health professions are in desperately short supply. Most individual members of these professions are addicted to a one-to-one, face-to face, psychotherapy model as the way to deal with the problems of all their clients. All, that is, except the poor, who get only drugs or shock.

All of the brave talk about community mental health and about consultative roles represents just a double handful of people talking to each other. It is increasingly difficult to get professionals to work for salaries; most prefer private practice. Even if they are willing to accept salaried positions, they are increasingly reluctant to work in local and state tax-supported agencies and clinics. It is going to become even more difficult to recruit professionals as the supply dwindles.

There is little evidence of any significant proportional increase in available professional resources in the mental health professions since the national manpower study eight years ago (Albee, 1959). Everyone agrees that the United States should be producing 11,000 new physicians a year (U.S. Dept. of H.E.W., 1959) *in order simply to hold our own* against population increase and to provide replacements for the physicians who retire or otherwise leave the field. But our medical schools are *not* producing this number. In fact, they turn out at least 3,500 fewer than this figure, year after year. So the only possible conclusion that can be drawn is that physicians are in steadily decreasing supply in ratio to population.

As psychiatry is a medical specialty, it does not seem logical to think that the supply of psychiatrists can increase, over any appreciable number of years, when the supply of physicians is decreasing. Temporary gains are made by the cynical practice of importing foreign physicians as underpaid house officers, by whipping up special programs for unhappy general practitioners, by hard-sell recruitment programs, and by other emergency measures. But because the basic supply of physicians coming off the end of the pipeline each year is at least 40 per cent below the number required *to stay even,* the supply of psychiatrists cannot help but decrease in the long run.

Nor is the situation any more hopeful in psychology or social work. If anything, psychologists will be in even shorter supply than psychiatrists in the future. In addition to being in great demand for the burgeoning mental health activities, psychology, traditionally an academic discipline, must provide the teaching manpower for the nation's undergraduates. Practically every Ph.D. in psychology turned out in the next ten years could be absorbed by the unbelievably high demand for new college professors created by a doubling of the undergraduate enrollments and the increasing popularity of psychology as an undergraduate subject.

In addition, psychology is no longer the young profession it was twenty years ago. The age distribution of psychology faculty is gradually approaching the age distribution of faculty members in general. This means that soon it will be necessary to step up the rate of replacement of aging college professors of psychology, who will be leaving the field in increasing numbers (Albee, 1963).

The shortage of social workers is so clear and well documented that it need not be repeated here. The most frequently quoted statistic is that there are twenty jobs for each MSW graduate.

So the day of reckoning is moving closer.

Up to the present time there has been little in the way of organized protest from the poor about the unavailability of outpatient services or about the lack of proper professional care in our tax-supported "hospitals." The poor, characteristically inarticulate and disorganized, have been the ones who have suffered in silence. But union members are not poor, and unions are not inarticulate! If unions have been led to believe that professional help is available and if they have negotiated these benefits and announced to their membership that professional time *will* be available, they are going to be impatient when they discover that time is *not* available and when they begin receiving complaints to this effect from their members.

Congress is also in the picture. The report of the Joint Commission (1961) encouraged Congress to believe that, in federal partnership with the states, something could be done to improve care and reduce the prevalence of mental illness. It accepted the assurance that, given the funds for construction and staff salaries, a new day would dawn for the "mentally ill." The day will be long adawning!

Is there any hope for a breakthrough, for a new and imaginative solution that will relieve this pessimistic situation? Perhaps, eventually; things are going to get *so* bad that new models will *have* to emerge.

For several years it has been fashionable to say that the best hope for solving the desperate professional manpower shortages in mental health will be found when a research breakthrough is made in establishing the cause and cure of one or more of the more prevalent mental "diseases." This kind of statement is usually interpreted to mean the discovery of some imbalance which will lead to a pill, drug, operation, or injection which will cure schizophrenia, or will remove symptoms of neurotic tension and anxiety, or will in some manner correct the structural, chemical, or other biological imbalance which is causing the mental disease. As a consequence of this breakthrough fewer professional people will be needed, bringing manpower demands more in line with supply.

But it may be that our manpower problems will not be solved, and cannot be solved, until there has been a *conceptual* breakthrough with regard to the causes and remedies of most forms of mental disorder. The whole professional field of concern with mental disorder, and of mental health manpower planning, is dominated by the concept of *mental disease,* when in reality most mental disorders may be primarily learned patterns of socially deviant behavior which are inappropriately conceptualized in the *disease model.*

Actually, the research breakthroughs may have been made already, but because of the limitations imposed by professional language, values, and cultures, we have failed to recognize their implications. Many psychopathologists would agree with the argument that most neurotic and functionally psychotic mental conditions are more social than biological in causation. But little of the potential of this consensus has been felt in institutionalized care-delivery systems.

Research has already demonstrated that psychopathology increases as the integrity of the family is damaged or destroyed and that, conversely, the amount of psychopathology is low in groups where the stability and strength of the family is high. Children from well-integrated families have very low lifelong rates of mental disorder, and children from emotionally disrupted families have high subsequent rates (see Sanua, 1961, for example).

While all mental disorders conceivably can be included under the dictionary definition of *disease,* so also could many other prevalent human problems such as prejudice. The difficulty is that the consequences for action which derive from a decision to call either schizophrenia or prejudice diseases are inappropriate solutions to reducing the incidence of either condition. The identification of these conditions as disease leads, logically, to local, state, and federal planning for medical care, nursing care, hospitals, beds, and ultimately for investment of funds in biological research aimed at discovering their organic causation.

So long as the disease model prevails for neurotic and functional psychotic mental disorders, our society will limp along with too few medical and paramedical professional people attempting to treat sick human beings in hospitals and clinics with minimal effectiveness or appropriateness. When the sickness model ultimately is laid to rest, society can set about training new kinds of professionals, closer perhaps to school teachers than to psychiatrists, to work with these disordered people in new kinds of institutions, patterned on schools rather than on hospitals.

In view of its inappropriateness, how is it possible to account for the persistence of the disease model in the field of functional behavior disorder? First, it served as an excellent humanistic substitute to the older explanations of uncontrolled behavior which ascribed causation to sinfulness, taint, or demonic infestation. These explanations had prevailed until the humanitarian movements of the late eighteenth and early nineteenth centuries. The rise of science, the logical and programmatic successes of taxonomy and of disease classification, and the widespread replacement of superstitious religion with scientific rationalism combined to make the disease model, and efforts at nosology, seem proper and progressive when applied to the insane.

Second, the disease model received wide acceptance due to the phenomenal success of medicine and its basic sciences in uncovering and revealing the unseen world of microbiology and the elaboration and successful application of the germ theory of disease.

In the field of biological research, too, one disease after another yielded to the persistence of scientific investigation. The elimination of typhoid fever, of smallpox, and of other plagues that had beset mankind from earliest recorded history and the further triumphs of physiological medicine in controlling diseases such as diabetes combined to raise hopes that the great mental scourges would be the next to yield. Indeed, the persistent investigation of "General Paralysis of the Insane" over a period of two hundred years finally led to the discovery of the role of the spirochete in the development of paralytic-cum-mental symptoms, and then soon after to malaria treatment, and eventually to a sharp reduction in the incidence of general paresis. A similar success in uncovering the role of vitamin deficiency in the production of pellagral psychosis further added to the promise of the disease model (Zilboorg & Henry, 1941).

It seemed just a matter of time until biological, biochemical, or neurological discoveries would lead to the research breakthrough which would produce a comparable reduction in the incidence of schizophrenia or manic-depressive psychosis. The apparently growing evidence of a genetic factor in these conditions was almost the clinching argument for the structural-physiological disease model of behavior disorder.

Third, the disease model has persisted because it supports the chronic social inclination to write off current victims of severe emotional disorder as Lost Ones, who should be given at least minimally adequate shelter and food but for whom there is little hope because of the irreversible nature of most of the disease processes with which they are afflicted. The victims themselves have cooperated by regressing and withdrawing into a world of bizarre fantasy and behavior in the absence of effective intervention. Public fear and horrified fascination for the insane asylum formed the *zeitgeist* which continued to nurture the cultural vision of hopelessness and irreversibility.

A related, powerful source of support for the disease model involves the appeal of the strategy demanded for seeking a reduction in the incidence of "mental disease." If mental disorder is indeed a disease, then funds can be spent in good conscience for research seeking the neurological, biological, and chemical causes and society can convince itself that it is doing its best to eliminate mental disease. If on the other hand, mental disorder is eventually acknowledged to be largely social and cultural in origin, the consequences for action will be very serious, if not downright dangerous, to the status quo. It may be necessary to direct our efforts at prevention to the modification of social institutions which now enjoy strong support from those favoring the status quo. For example, if it is acknowledged that discrimination, with consequent unemployment, poverty, broken families, and poor housing, is a major cause of emotional disorder, then social action to insure employment, decent housing, and equal social participation is indicated as the remedy for mental disorder, not more biological research. Understandably, this solution may be more threatening to many than a sickness model which does not require social remedies.

Another source of support for the disease model is the very understandable reluctance of families of mentally disordered people to acknowledge any personal responsibility for the emotional disorder. If a functional mental disorder can be regarded as "an illness just like any other," then the families are absolved of guilt; if the causes of the disorder are independent of human interaction, then Fate can be judged responsible.

Perhaps, however, the most compelling reason for the persistence of the disease model has been the absence of a satisfactory alternative model. There is a well-known rule in politics that "you can't beat somebody with nobody," and the same thing is true in science. A scientific model will persist, despite its incorrectness or absurdity, until a more valid and heuristic alternative appears.

In recent years there has begun to emerge out of psychodynamic theory, social work, experimental psychological research, and psychotherapy the elements of a theoretical model which might be termed the *Social-Learning Theory* of mental disorder. In very general terms this approach suggests that most emotional disorders are complex, learned behavioral patterns reinforced by their effectiveness in anxiety avoidance. The origin of the anxiety to be avoided is to be found in unfortunate emotional conditioning during the first few years of life in social interaction with significance adults, usually the parents. It is thus held by a growing number of behavioral scientists and professionals that many emotional disorders are acquired defects in *social* interaction and *social* participation. Evidence continues to accumulate from the laboratory, from psychoanalysis, and from psychotherapy in general that sociocultural conditions which influence the stability and strength of the social world of the infant and child have profound effects on the rate and kind of subsequent emotional disorder.

Another developing line of evidence suggests that alternative (and social) explanations may account for the very convincing figures on the role of hereditary factors which have been reported for years. Not only has the genetic work been examined and found to contain flaws which make it less than convincing, but recent germinal discussion of the data (Jackson, 1960) and even more recent research in Finland (Tienari, 1963) suggest that the genetic evidence is not sufficient to convict in the Court of Occam.

The real mental health problems have not yet been faced squarely. The real mental health problem of our nation is represented by a little girl being born today to a Negro mother who has been abandoned by her husband and is living on inadequate relief in the heart of the urban slum. This little girl's chances of being mentally retarded are ten to fifteen times greater than those of her sister born today to a white mother in suburbia. This little Negro girl will weigh 500 grams less than the child born in the same hospital, on the private service, to a white suburban mother. Her low birth weight will be due in part to dietary deficiencies during her mother's pregnancy.

More than one-third of all mothers in cities with populations of over one hundred thousand are "medically indigent." In our major cities as many as sixty per cent of the mothers entering public tax-supported hospitals for delivery of babies have received little or no prenatal care.

Due either to her poor start or to the inability of her mother to give her enough love and consistent attention, our little Negro girl is ten to fifteen times as likely to become a schizophrenic when she grows up as is the other little girl born upstairs. She starts out behind the eight ball, growing up in an urban slum, without an adequate physical or emotional diet, without adequate intellectual stimulation, without learning the language used in the polite outside culture. If she is unable to do well on verbal intelligence tests devised by middle-class psychologists and is adjudged retarded, she has had it. Of the one and one-quarter million retarded children of school age today in the U.S., three-quarters of them do not have access to any kind of special education (U.S. Dept. of H.E.W., 1963). We are not training teachers to work with retarded children (nor with emotionally disturbed children), nor are we training professors to train the teachers to work with them.

As long as we think of this girl as mentally ill—whether as a mentally retarded child, as a juvenile delinquent, or as a young schizophrenic—we will not have the manpower or the concepts required to help her or to prevent future similar problems. As long as we try to "help" her by looking only for the chemicals responsible for her retardation, the brain defects that make her an "incorrigible acting-out delinquent," or the tranquilizers to blunt her adult schizophrenia, there is no hope of sufficient manpower or viable kinds of treatment. But once it is finally recognized and accepted that most functional disorders are learned patterns of deviant behavior, then the institutional arrangement which society evolves to deal with these problems probably will be *educational* in nature. It is already widely recognized that properly utilized behavioral modification techniques prevent the serious desocialization which accompanies hospitalization on the back wards. Using college graduates with special training in reeducational techniques, it will be possible for society to develop new institutional forms that require manpower rather easily recruited and trained. While it is difficult to anticipate the forms which such institutions may take, it is quite possible that they will be combinations of present day-care centers recast as small tax-supported state schools with a heavy emphasis on occupational therapy, reeducation, and rehabilitation.

Admittedly the social therapy which may be indicated need not be psychotherapy, and the professionals of the future may be trained in techniques of social interaction and social conditioning rather than in one-to-one relationships. It seems likely, however, that the field will need individual psychotherapists for a long time as a major source of insight into patterns of mental disorder which emerge as a consequence of changing social structures.

Under the rubric of the disease model the institutions which society has evolved to care for emotionally disturbed and mentally disordered children and adults are inadequate and inappropriate, and this situation is bound to get worse. Because it will take several generations, a century perhaps, to replace the illness model with a social-learning model as an explanation of mental disorder, the nation must face the next several decades with a realistic understanding that the mental health manpower picture is going to worsen because it cannot train enough professionals to meet the manpower needs the disease model demands.

Any manpower planning effort must confront these realities. By persisting in using an illness model of mental disorder not enough professional people are available to deal with the nation's growing need. This would not in itself, of course, be sufficient reason for abandoning the illness model if it could be shown to be valid. But it is not valid, and so we are trapped in a blind and hopeless alley conceptually. A conceptual breakthrough is needed that can lead to manpower solutions and institutional solutions which can now only dimly be perceived.

REFERENCES

Albee, G. W. *Mental health manpower trends.* New York: Basic Books, 1959.

Albee, G. W. American psychology in the sixties. *Amer. Psychol,* 1963, *18,* 90-95.

Albee, G. W. Manpower needs for mental health and the role of psychology. *Canad. Psychol.,* 1965, *6a,* 82-92.

Jackson, D. D. *The etiology of schizophrenia.* New York: Basic Books, 1960.

Joint Commission on Mental Illness and Health. *Action for mental health.* New York: Basic Books, 1961.

Sanua, V. D. Sociocultural factors in families of schizophrenics: a review of the literature. *Psychiatry*, 1961, *24*, 246-266.

Tienari, P. Psychiatric illness in identical twins. *Acta Psychiatrica Scandinavica*, 1963, Supplementum, *171*, Vol. 39, Munskgaard, Copenhagen.

U.S. Dept. of Health, Education, & Welfare. *Physicians for a growing America.* Washington, D.C.: GPO, 1959, Public Health Service Publication No. 709.

U.S. Dept. of Health, Education, & Welfare. *Mental retardation.* Washington, D.C.: GPO, 1963.

Zilboorg, G., & Henry, G. W. *A history of medical psychology.* New York: Norton, 1941.

5

MENTAL HEALTH MANPOWER AND INSTITUTIONAL CHANGE[1]

Robert Reiff

Department of Psychiatry, Albert Einstein College of Medicine

Mental health manpower problems may be approached from many different points of view. The most fruitful approach is to begin with the greatest social need and to examine what the manpower resources are and their potential for meeting it.

In recent years there has been a growing and vital concern of the professional in human services and the more enlightened public-service-minded government agencies for reaching the lower socioeconomic groups, and particularly the poor. The increasing recognition that there is a vast multitude of people with unmet needs has resulted in two national programs—the community mental health program and the antipoverty program. Both of these programs have as their aim attention to the problems of those in society whose needs are greatest. Both are concerned with developing programs in the community.

It is to the credit of professional and political leaders that both these programs have come into existence as a result of their sense of social responsibility, their vision, and their initiative, but without the stimulus of a vocal and organized demand from the suffering people themselves. The absence of such a demand from below poses a question of crucial importance. What strategies can be developed to *convert the very great existing need into effective demand for services?*

A great deal of productive thinking is going into this problem. Many new strategies relating to program, technology, and other aspects are being devised and demonstrated. The extent to which these will succeed depends ultimately on three factors: whether the services offered are appropriate, whether they are utilized, and whether there is sufficient manpower (Reiff & Scribner, 1963). These factors are closely interrelated, but before the manpower question can be tackled it is necessary to understand what accounts for the lack of utilization of present services by the poor, and if change is necessary, what must be changed to make them appropriate.

---

[1] This chapter appeared as a paper in the *American Psychologist*, 1966, *21*, 540-548, and is reproduced with permission of the American Psychological Association.

The development of mental health services has been one of increasing acceptance on the part of the middle and upper classes in this country. There has also been an ever-increasing expansion of its influence on child rearing practices, education, marriage, etc. In fact, there is hardly an area of social living over which the umbrella of the mental health professional has not been extended. On the other hand, there has been a long history of persistent alienation from mental health professionals of the lower socioeconomic groups in this country (Bockoven, 1963). This alienation represents a critical failure. It is not merely the failure of each individual mental health professional, although there is the element of the individual's social responsibility involved here. Neither is it primarily a matter of tools and skills, although, again, this element is also involved. Basically, the problem is an ideological one. The roots of this alienation from the low-income populations lie primarily in the middle-class ideology of contemporary mental health services and secondarily in its technology. Ideology is probably most often used to refer to attitudes and values of people. This is not the sense in which it is used here.

By ideology is meant the body of knowledge, the set of integrated assertions, theories, and aims, primarily psychoanalytical, which constitutes the individualistically oriented program for restoring to society the mentally sick and socially deviant.

There is a basic dichotomy between the popular point of view about mental illness and mental health, and the mental health professionals' point of view. Studies by Star (1957), Reiff (1960), and others have shown that the popular point of view starts with normal behavior as its reference point. It seeks to explain normal behavior as the distinctive and essentially human qualities of rationality, and the ability to exercise self-control. Given this premise, normal behavior is viewed as a rational response to the immediate circumstances in which the individual finds himself, which is at the same time fully within the conscious control of the person. Mental illness is defined as the extreme opposite of normality. It is behavior in which rationality is so impaired that the individual has lost control and can no longer be responsible for his acts. It is, therefore, quite logically, only the extreme form of psychosis which is considered mental illness by most workers. It follows from this that mental illness is a very threatening thing. It represents a loss of the distinctly human qualities, the ultimate catastrophe that can befall a human. Thus, in their view, mental health and mental illness are not related to each other as on a continuum but they are discontinuous phenomena.

The professional point of view starts with abnormal behavior as its reference point and extrapolates to the normal. It views mental health and mental illness as on a continuum, and it holds that personality characteristics and behavior are *universal,* differing only in degree. It contends that there is really no such thing as a completely normal person, and that the same phenomena seen in mental illness are present in all people. In fact, mental health professionals can hardly use the word "normal" without prefacing it with the words "so-called" normal. Further, the professionals' point of view holds that characteristic emotional patterns are not entirely within the rational control of an individual. The modifications of behavior patterns do not depend entirely on rationality, self-help, willpower, reasoning, or even purely environmental manipulations. It assumes that a large part of our motivations are unconscious or unknown to us and that until they become conscious they are unmodifiable. Finally, the professionals' point of view makes the implicit conclusion that mental illness is not necessarily an overwhelming threat nor must it inevitably arouse fear or alarm. But, while it may be reassuring to a middle-class patient to hear that the emotional mechanisms of sick people are not so different from anyone else's, it is anything but acceptable to a healthy worker that his emotional mechanisms are not so different from the mentally ill, especially if he holds the point of view that mental illness is about as far from normal as you can get. It is not being suggested that the validity of a scientific concept depends upon its popular acceptance, but merely that a practical concept of normality is necessary to find a basis of understanding with low-income groups essential to successful treatment as well as primary and secondary prevention (Jahoda, 1958). The key to developing such a practical concept of normality is the recognition that, though personality characteristics and behavior may be universal, their meaning and significance for illness and health must be assessed within their social-cultural context. The failure to control violent acts of aggression has different implications for normality and illness in a civil rights demonstration, a quarrel in a working-class bar, a middle-class family quarrel, or a meeting of clinical psychologists.

Furthermore, while the worker acknowledges there is such a thing as mental illness which he equates with severely psychotic behavior, from his point of view he has difficulty accepting the concept of a neurotic emotional disturbance as an illness. The term itself is confusing to him. If he sees a raving psychotic screaming or a psychotic depressive crying and wailing, he can see how that can be called emotionally upset. In that sense it is simply a synonym for excessive emotional behavior out of control. However, if he is told that a man with a lame back or a particularly passive person who lets everybody walk all over him is emotionally disturbed, this idea of sickness is incomprehensible to him. To him there is physical illness and mental illness. In mental illness one sometimes sees severe emotional upsets. Sometimes people get upset over physical illness, death, stressful situations; but to him this is not mental illness. It is either a normal reaction to a stressful problem of living or a sign of physical or moral weakness. It follows then that the professional point of view, that failure to meet the problems of living is an emotional disturbance, a milder form of mental illness, to be treated by the same kind of doctor that treats the more seriously mentally ill, only alienates him. To the worker, emotional disability or impairment is either related to a physical illness and should be treated as such by the doctor, or it is the result of undue stresses or strains in the environment; or it is related to a moral weakness and should be treated by a minister or priest or conquered by oneself or accepted and lived with. If one attempts to treat what is considered to be a moral weakness, the worker, with his present view, considers it a tremendous invasion of his privacy. Also, the general practitioner reinforces his tendency to identify emotional disturbance with physical illness, by making it so easy for him to find a physician to treat it as physical illness. Can present professional ideology make an impact on the "moral weakness" problem? It can, of course, work through ministers and priests. That may help the small minority who seek help from them; but for the most part, there is little hope of getting workers or low-income groups to accept failure to meet the problems of living as an illness, and as long as problems of living continue to be diagnosed as diseases and treated within an institutional framework for the treatment of disease, the alienation will persist (Szasz, 1961).

The present ideology and technology of mental health professionals will continue to fail with low-income patients unless the focus is shifted. Riessman (1964) points out that low-income people are task oriented, concrete, concerned primarily with the here and now and focused on solving immediate problems. If they have troubles they are interested in finding a way to cope with them. If they are to be helped the response must be to their need, as they see it, for more successful coping techniques. It is necessary to shift the focus from how they are *reacting* to how they are *acting*, from *defensive reactions* to *coping styles,* from changing their reactions to teaching them more successful *actions.*

This change of focus also has implications for the aims and goals of treatment. The fundamental justification and aim of most psychotherapy today is self-actualization. Everyone should realize his full potential, and if he is not able to do so, then he should be in therapy so that he may fully actualize himself. This, of course, meets a responsive chord in the feelings of most middle- and upper-class persons about themselves and their lives. They see themselves in many possible roles and their hope is to select those roles which enable them to actualize themselves. The view that one can realize his full potential presupposes a view of society in which there are many possibilities and opportunities and that one need only remove the internal difficulties to make a rich, full life possible. For the most part, disturbed middle-class patients see themselves as *victims of their own selves.* Low-income people, on the other hand, are not future oriented. They live in a world of limited or no opportunities. There is little or no role flexibility. They see themselves as *victims of circumstances.* Self-actualization under these conditions is meaningless to them. Before they can become interested in self-actualization, they have to believe that they can play a role in determining what happens to them. Thus, *self-determination* rather than self-actualization is a more realistic and more meaningful goal for them.

Another ideological problem is the domination of the treatment relationship by the values and mores of a "fee for service" ethic. Even where the service is rendered by an agency this is true. Goffman (1961) eloquently describes this relationship which he says involves a set of interdependent assumptions that fit together to form a model.

> . . . When services are performed whose worth to the client at the time is very great, the server (that is, the professional mental health worker) is ideally supposed to restrict himself to a fee determined by tradition—presumably what the server needs to keep himself in decent circumstances while he devotes his life to his calling. . . . When he performs major services for very poor clients, the server may feel that charging no fee is more dignified (or perhaps safer) than a reduced fee. The server thus avoids dancing to the client's tune, or even bargaining, and is able to show that he is motivated by a disinterested involvement in his work.
>
> The server's attachment to his conception of himself as a disinterested expert, and his readiness to relate to persons on the basis of it, is a kind of secular vow of chastity and is at the root of the wonderful use that clients make of him. In him they find someone who does not have the usual personal, ideological, or contractual reasons for helping them; yet he is someone who will take an intense temporary interest in them. . . . It therefore pays the client to trust in those from whom he does not have the usual guarantee of trust.
>
> This trustworthiness available on request would of itself provide a unique basis of relationship in our society . . . (pp. 327-328).

These implicit characteristics of the therapeutic relationship are understandable and acceptable to most middle-class people who themselves are often engaged in trading their expertness to other individuals. But the worker finds it difficult to trust the person who expects a fee for helping him with what he believes to be a moral problem. Children, too, have difficulty understanding; and they are confused when they discover that the therapist is paid for "being his friend." Thus, the treatment relationship itself is confusing and untrustworthy in the eyes of low-income people. The fact is that for any person in a low-income group, having a mental illness means being a medical indigent with all the unhealthy effects this situation has on a person's self-esteem.

In addition to these there are the ideological differences in the more usual sense, values, goals, and styles of life between the low-income patient and the professional himself which effect communication and the nature of the relationship between the two (Reiff & Riessman, 1965).

It is clear that what will be required first are bold and even drastic changes in the mental health service, within the professional structure, and in the professional himself. The innovator of such institutional change will need to break out of the mold of institutional thinking and to be constantly alert to all the forces within the professional ideology, within the technology, and within himself that are constantly straining to oppose or weaken innovation.

Already the weakening of innovation can be seen in the comprehensive community mental health program enacted into legislation which promised to change the whole nature and direction of treatment for mental illness in this country. The idea that the mentally ill can be treated in the community is relatively new and has become possible because of advances in drug therapy during the last 10 or 15 years. The new drugs, although they do not cure mental illness, often change the behavior of the patient sufficiently so as to make it possible for him to live in the community with certain kinds of support from its resources. This has led to a shift in emphasis, a change in goals, in the treatment and care of the mentally ill. Once, custodial care was the only alternative to the failure to qualify for treatment. Now, with an emphasis on a return to functioning rather than cure, rehabilitation and habilitation have become the organizing goals of the treatment process, and the alternative of institutionalization is less necessary.

It has been proclaimed that the community mental health development signals a revolution in mental health [care]. Such a view is a gross exaggeration. The concept of community mental health has the potential for introducing revolutionary innovations, but a sober look will reveal that institutionalized community mental health under the Federal programs tends to become an extension of current professional ideology with modified goals, tactics, and techniques, over that part of society from which it has been hitherto alienated. It is in fact a process of consolidation rather than revolution, a consolidation motivated by the realization of the failure to adequately perform the social function of restoration of those whose needs are greatest. Such a consolidation may be a step forward. But it must be kept in mind that it solves none of the ideological problems but rather perpetuates them. It does more: It legitimates a two-class system of mental health treatment in this country—self-actualization for the rich, rehabilitation for the poor. To hail this as a revolution will only result in increasing cynicism and discouragement both among the poor and the professional as well.

Sometimes changes in tactics or techniques are necessary and sufficient to solve a problem. Miller and Rein (1964) point out, however, that frequently when professionals face the issue of ideology they escape into technology. But when the problem has ideological roots, changes in techniques without the necessary ideological innovations often result in nothing more than old wine in new bottles. Witness what is already happening in many instances to the walk-in clinic. The idea of the walk-in clinic was a bold attempt to deal with the problems of delay in providing service. It was to be the means of doing away with the problem of waiting lists, delayed referrals, etc., and its primary purpose was immediacy of service. It was to be the means by which the mentally ill could enter and be routed without delay to whatever kind of service was needed. It was to be the open door to a full array of comprehensive services.

But for the most part the new walk-in clinics have become brief psychotherapy clinics. The idea of an open door to comprehensive mental health services has already in many instances been converted into the old revolving door. They have become brief psychotherapy clinics because that is what the professionals who man them know how to do. They have spent many years acquiring psychotherapy skills and they want to practice what they know. Here, out of this little illustration, emerges a major mental health manpower problem. A really innovative community mental health program requires greater clinical skill, knowledge about social process and social organization, and an ability to be versatile in shifting one's focus from individual, to group, to social systems.

Community mental health programs are becoming institutionalized before the manpower with the appropriate skills necessary for its new operations can be trained. Out of necessity they will be manned by traditionally trained professionals who will practice what they know.

Comprehensiveness, an important aspect of the new programs, is slipping away. In some instances, the situation has developed where the kind of treatment patients get depends on which door they walk into. If they come to the walk-in clinics they get brief psychotherapy, if they come to the outpatient clinic they get long-term psychotherapy, and if they come to the emergency room they get drugs, or are hospitalized.

Rehabilitation, the major goal of the community mental health programs, hardly exists. First, because traditionally trained mental health personnel know little or nothing about rehabilitation, and second, because of the ineffectiveness of present rehabilitation programs.

These are some of the ways that the manpower problem threatens the community mental health programs. The manpower problem, however, is fundamentally inseparable from the problem of institutional change. Changing institutions of training is a slow and painful process and meets with great resistance from faculty and students alike, both of whom are much more interested in traditional psychotherapy training. There is still a great demand for this kind of mental health service. When it comes to providing psychotherapy to middle-class patients there is indeed a manpower shortage.

By its very nature a manpower shortage sets in motion a compelling drive to deal with the problem from an empirical short-range point of view. The need is urgent and immediate and there is a tendency to feel that if only we had more "bodies" our problems would be solved. Those who take this viewpoint look to the industrial model for solving manpower shortages.

The industrial model is to break up complex highly skilled operations into a series of more simple tasks. The simplification of the production process reduces the amount of training necessary and thus makes increases in the manpower pool feasible. Human services cannot be simplified in the same way without dehumanizing them. The last 20 years of medical practice have amply demonstrated that.

In the past, industry's manpower shortages were created by a sudden and urgent need for increased production when machines alone could not do that job. Today, industry's manpower crisis is of a different kind. Not manpower shortage but manpower excess plagues it and it has no solution.

But today, in mental health, we still look to the old industrial model and talk about breaking down the professional role into subprofessional classifications or subroles, each of which may be filled by people with less than complete professional training and whose training is specific to the roles. This model is proposed by Jesse Gordon (1965). It is the model out of which grow programs such as Margaret Rioch's (1965) training of mental health counselors. Paradoxically, her counselors probably receive better psychotherapy training than the majority of social workers, psychologists, and residents get. They fill a real need in providing manpower to traditional existing services. But her counselors do nothing new. They simply render some aspect of service that mental health professionals give and as such are a useful stop gap attack on the manpower problem. But from the point of view of greatest social need this solution contributes little because it is based on the assumption that manpower shortage is the crucial factor in the failure to tend to the problems of those in society whose needs are greatest.

Nothing could be further from the truth. The mental health professionals' posture is not that of a group of people with a successful product harassed by a clamoring demand, it is more like a group of desperate men struggling to hold back a flood and who cannot find the hole in the dike. This kind of manpower crisis is totally different from the usual shortage, for while it is true more bodies are needed to stem the tide, unless the hole is found and repaired or the water redirected, it will be a losing battle.

There are some who suggest that any attempt to halt the tide of mental illness by treatment alone is doomed to failure and that it would be better to concentrate efforts on primary prevention. The idea has great promise. Duhl (1963, 1964) has pointed out the compelling need to direct our energies toward changing social systems for the benefit of whole communities and societies. But here too there is a manpower problem. The fact is that there is hardly anyone in the mental health profession or the behavioral sciences who is trained in a body of knowledge, a set of concepts, or an adequate theory on which to base such training. But this is the greatest need and the most promising approach. What is needed is a new profession of experts in changing social systems for the prevention of mental illness and for the improvement of the psychological effectiveness of all individuals in society to deal with the problems of living. It is an exciting prospect but it also contains the same problems of manpower and institutional change.[2]

Caplan (1964) has pointed out that primary prevention should be an integral part of community mental health programs. He sees no basic contradiction in the requirements of the clinicians' role which is primarily consultation and treatment, and the requirements of changing social systems. He acknowledges that there may be difficulties but feels they are basically compatible. Actually, at present the prospect of any really effective primary preventive programs in community mental health—at least in the ones that are being planned now—is minimal; first, because with a few outstanding exceptions, institutionalized community mental health is not taking this direction and, second, because few clinicians, even those in community mental health, have the know-how. And finally, even more importantly, the social criticism, reorganization, and institutional change needed require the concepts and technology of social scientists; and the functions of social scientists and clinicians are, at this stage of our knowledge, not easily integrated. Reciprocity between the two is all that can be achieved given the present state of knowledge. The social function of a clinician and of a social scientist are different.

---

[2] In my early thinking about the problem, I thought that this new professional would be a social systems clinician, with a combination of clinical training and social science. But as I help develop social action programs and try to stimulate other clinicians to think about them, I am rapidly becoming convinced that clinical training with its emphasis on changing the individual and its focus on the psychodynamic or interpersonal is an impediment to thinking about changing social systems.

It is necessary to recognize how society is affecting and frequently limiting the development of the mental health professions. Miller (1963) calls attention to the fact that professionals often act as though all they have to do is to decide what professional skills are necessary and that will solve the social problems. They act as though there are no social forces other than those they set in motion operating on the profession.

At the present time there is no adequate theory or set of concepts which integrates the social process and the individual. Until such a time the clinician, who is the repairman, and the social scientist, who is the engineer, perform different social functions. These two functions have different concepts, values, motivations, interests, and aims as well as different roles. Every social function for which there is a need tends to become institutionalized, and the process of institutionalization tends to rigidify and restrict the role necessary to accomplish the function. The result of this institutionalization process is to rigidly define the professional role and to proscribe sanctions for those who may be tempted to contaminate their function through role flexibility. In the absence of an integrative *theory* the social forces at work on professional roles will prevent the integration of the social scientist and the clinician. The best that can be hoped for is a reciprocal team-type relationship between the two until such time as a new professional emerges.

But it is not necessary to wait for a theory. What is needed is to start now to develop a body of knowledge and to encourage social and behavioral scientists, and mental health professionals, to become *participant-conceptualizers* in community action programs and public service functions where they will have the opportunity to influence decisions on social changes.

This opportunity now exists in a social program which is outside of the community mental health program—but which has the potential for playing a more decisive primary prevention role than the community mental health program. The Community Action Program of the Office of Economic Opportunity is in much better position to succeed where the mental health professionals have failed because it is not bogged down by the difficulties inherent in the ideology of mental illness.

The Community Action Program addresses itself to the normal. The poor are not considered sick. The goal of the poverty program, particularly the Community Action Program, is self-determination not self-actualization. Its focus is on coping techniques, not on psychodynamics. In brief, it is free from many of the characteristics of the mental health professionals' ideology which make for alienation. Thus, it has a better chance of reaching and maintaining contact with the poor. It is an excellent opportunity for mental health professionals to become involved in social action, a prerequisite for anyone who wishes to become engaged in primary prevention. It is a significant reaffirmation of all that is being said here, that, for the most part, the new community mental health programs are being developed independent of and isolated from the most significant development in urban communities in the United States in the last 20 years, i.e., the Community Action Programs.

There are one or two places, however, which have become exciting experimental labs for community mental health social action programs. The Neighborhood Service Center of the Lincoln Hospital Mental Health Program is one of these (Peck, Riessman, & Hallowitz, 1965). It has been and continues to be a great learning experience. In it was revealed all of the tensions, conflicts, attitudinal, and ideological differences that have been mentioned here. Yet, the mental health professionals have remained excited, cohesive, and their spirit and working relationships could not be better. Out of such laboratories as these we may learn how to develop a social systems mental health specialist.

One of the most exciting aspects of community action programs is the use they make of nonprofessionals recruited directly from the ranks of the poor in the neighborhoods they serve.

There is no question that the use of these new nonprofessionals opens up a great reservoir of manpower for mental health activities as well. But, unless this manpower is used effectively they can become nothing more than wardens and nursemaids tending the mentally ill who are waiting for the professional to serve them. They can also become a garbage heap where the professional dumps the patients he feels he can do nothing for. And, finally, the nonprofessional can become the menial who performs all the "dirty work" that the professional resents and wishes he could get rid of so that he could have more time to do the same old things. Used this way, the nonprofessional will reinforce all the tendencies in institutionalized mental health practice that mitigate against change.

Reiff and Riessman (1965) have pointed out that the ability of the nonprofessionals to do the things that the professionals cannot do, such as, establish a peer relationship, take an active part in the patient's life situation, empathize with his style of life, etc., is bound to affect the nature of the mental health services, the role of the professional, and may even have an impact on the ideology of the mental health professional. The training of the nonprofessional then, becomes itself a strategy for affecting desirable change in the field of mental health. The demand characteristics of the effective use of the new *nonprofessional* in this way will of necessity create a new *professional.*

Through the nonprofessional the professional has a greater repertoire of preventive, remedial, treatment, and care modalities. But the nonprofessional cannot decide what kind of service the patient needs. Rapid and appropriate assessment of each individual case will be required. Thus, the new professional will have to become skilled in making early assessments and referrals to the appropriate modalities. This is in contradistinction to quick and rapid assessments that are made in today's emergency rooms by first-year residents. Appropriate use of the nonprofessional will require the judgment of the most highly skilled clinicians who are thoroughly familiar with all the modalities of care, and who have developed criteria for making such decisions. Furthermore, the role of the professional will change. He will need to be more of a consultant, supervisor, and administrator. And if he should venture into primary prevention or become involved in community action programs, he will probably also be required to play the role of organizer, politician, and educator. All of which will compel him to face new conceptual problems, such as when does community action become political action, how shall he differentiate his citizen role from his professional one, etc. One thing he will need to learn for certain is the harsh reality of power struggles.

One cannot enter the field of institutional change without forthrightly facing power issues. The problem of creating institutional changes in mental health cannot be solved by the strategy of manpower alone. Bureaucratic and professional rigidities are not matters of protecting practices alone but, in the final analysis, are power issues. There is a tendency among professionals to ignore power issues and to act as though intelligence and rationality will conquer all. But the power issues are there, and more often than not, determine the outcome of efforts at change and innovation. Within the field of mental health there are both intraprofessional and interprofessional power issues which limit the efforts of those who are struggling for institutional change. It often happens that intraprofessional power issues get contaminated with interprofessional ones. For example, the recent attempt of neuropsychiatrists to take legal action against a therapy training institute of psychologists. Interprofessional power issues, however, seldom became intraprofessional ones because the risk of losing an intraprofessional power struggle is greater than in an interprofessional one. The most significant power issue in changing the field of mental health will inevitably be around the question of the medical model. At the present time, it appears that this is primarily an interprofessional struggle. Let us analyze the situation and see what are the likely effects of this power struggle on the development of new and innovative mental health programs and the utilization of new kinds of manpower.

Clinical psychiatry, responding to social pressures, developed its branch of social and community psychiatry so that now that legislation makes possible the development of community mental health facilities, psychiatry has a conceptual and a professional organization structure which can take responsibility for the community mental health centers. It is significant that no comparable organizational structure has grown within the professions of clinical psychology and social work. For this reason the institutional community mental health programs have been and will continue to be primarily influenced by the forces operating within the institution of psychiatry. They will reflect not only the innovative thinking of community and social psychiatry, but the powerful forces of medicine as well.

The clinical psychologist, on the other hand, is not recognized particularly by the other mental health professionals for his therapeutic skills and technology. He has never achieved recognized independent status in this area, but he is respected and recognized where clinical psychology has made a theoretical or technological impact on mental health from work which is indigenous to psychology. Modern psychoanalytic thinking, for example, has incorporated a great deal of academic developmental psychology. This is one of the heritages of psychology. Psychoanalysis draws heavily on developmental psychology. In this area, the clinical psychologist's views are respected. In psychological testing, again an area indigenous to psychology, modern psychiatry finds the contributions of clinical psychology useful and acceptable as an independent function. But as far as treatment is concerned, the clinical psychologist is regarded as ancillary. As long as psychologists continue to operate within the ideological framework of psychiatry this state of affairs will continue. When and if psychologists can overcome their own intraprofessional power issues and move into the field of community action and primary prevention on the basis of their own body of knowledge about normality, development, cognitive processes, and social psychology, only then will a truly interdisciplinary relationship with psychiatry be possible. This point is forcefully made by Rosenbaum and Zwerling (1964) who write

> The social scientist in his (the social psychiatrist's) milieu is not the familiar psychiatric social worker or clinical psychologist but rather the sociologist, the anthropologist, and the social psychologist. Whereas the traditional social worker and psychologist operate from within the framework of psychoanalytic theory, the social scientist operates from social system theory, and the psychoanalyst in a unit in social psychiatry is forced to work on a more truly interdisciplinary team basis (p. 34).

Clinical psychologists are not seen as extradisciplinary and, therefore, requiring interdisciplinary team relationships, but because clinical psychologists operate within the framework of psychoanalytic theory, they are seen as an intradisciplinary substrate of psychiatry, and, therefore, the relationship assumes a hierarchical rather than team form. Klein (1963) asks

> Will [the training of clinical psychologists] be geared to the nature and requirements of institutional social and community psychiatry just as clinical psychology developed with the needs of clinical psychiatry as a critical determinant (p. 2).

It is necessary to add to this the question: *Will they be able to develop a body of systematic knowledge, a set of integrated assertions, theories, and aims based on psychological tradition, which constitute a socially oriented program for improving the psychological effectiveness of all individuals in our society to deal with the problems of living?* Unless this is done the psychologists will continue to put themselves in the position of having to argue over rights to employ the technological skills which are rooted in psychiatric ideology. The issue will always be posed as one of skill; and as long as psychologists continue to justify their existence on the basis of technological skills, they condemn themselves to an interminable power struggle in the form of a jurisdictional dispute with the other sections of the mental health skilled trades. Power struggles on the basis of technology result in power struggles and nothing else. A power struggle on the basis of ideology can be an important catalyst for institutional change.

The introduction of the nonprofessional into mental health services will add a new dimension to the power struggle—that between nonprofessionals and professionals. Tensions will inevitably exist. If the nonprofessional is to serve the functions of doing what the professional cannot do he must be integrated into the mental health service establishment without being absorbed. He must be permitted to develop a power structure of his own.

In order to win a power struggle, one needs political clout. The political clout of community psychiatry lies in the Federal Community Mental Health Program. But this is fraught with dangers and too much subject to other political forces. The political clout of psychology and social work resides in their respective professional organizations and in their middle-class constituency, primarily in agencies.

One of the most effective forms of political clout is the development of a constituency. Rein (1965) has called attention to the power of the recipients of services. One of the major reasons why psychologists and social workers can do therapy is because they have an unorganized, informal constituency. These are the people who are asking for their help and for whom they fulfill a social need. But now that the social need is being redefined, clinical psychology and social work will need to build a new constituency. Meanwhile the pull of the old constituency will make it difficult to attract psychologists.

While it is true that there will continue to be a social need for psychotherapists working with middle-class patients, the direction of mental health *service* is shifting to low-income groups and meeting their social need. This paper tries to indicate some of the issues that will have to be faced if existing need is to be converted into *effective* demand. In terms of the power issues, that is another way of saying a constituency must be developed, a group of people within the population who are demanding the new mental health services being offered. The nonprofessional being closer to the people to be served can be of inestimable value in helping to develop this constituency. But here again the medical model, as has been pointed out earlier, limits the possibilities for changing the relationship between the professional and the poor, as well as between the professional and nonprofessional.

To summarize: The greatest social need for mental health services today comes from the low-income groups and the poor. Meeting this need is not primarily a problem of manpower but a problem of ideology. The task is to develop concepts, methods, programs, and services that are appropriate, effective, and related to the life styles of low-income people and to their needs, in a way which will create an effective demand for them. This will require significant institutional changes. Whatever manpower problems do exist are inseparable from the problem of institutional change. The solutions to manpower problems can reinforce existing institutionalized mental health [care] or they can constitute a strategy for promoting institutional change. Two things are certain. There is need for a *human link* between the professional and the poor; the new nonprofessional can be that link. And there is need for a new mental health professional; a man who is skilled in changing social systems to improve the psychological effectiveness of all people in society to deal with the problems of living. The road to achieving these is also the road to changing significantly the mental health services and professions of this country.

REFERENCES

Bockoven, J. S. *Moral treatment in American psychiatry.* New York: Springer, 1963.

Caplan, G. *Principles of preventive psychiatry.* New York: Basic Books, 1964.

Duhl, L. J. *The urban condition.* New York: Basic Books, 1963.

Duhl, L. J. Social planning. Paper read at Athens Center of Ekistics, Athens, July, 1964.

Goffman, E. *Asylums.* New York: Anchor Books, 1961.

Gordon, J. Project cause: The Federal anti-poverty program and some implications of subprofessional training. *American Psychologist,* 1965, *20,* 334-343.

Jahoda, M. *Current concepts of positive mental health, Joint Commission on Mental Illness and Health.* (No. 1) New York: Basic Books, 1958.

Klein, D. C. Community needs: A challenge for psychology. Paper read at American Psychological Association, Philadelphia, September, 1963.

Miller, S. M. Stupidity and power, two competing modes of explanation. Syracuse University, Youth Development Center, 1963. (Mimeo)

Miller, S. M., & Rein, M. Change, ferment and ideology in the social services. Toronto: Council of Social Work Education, 1964. (Mimeo)

Peck, H. B., Riessman, F., & Hallowitz, E. Neighborhood service center program. New York: Lincoln Hospital Mental Health Services, 1965. (Mimeo)

Reiff, R. The mental health education needs of labor. (Working Paper No. 2) Washington, D.C.: National Institute of Labor Education, 1960.

Reiff, R., & Scribner, S. Issues in the new national mental health program relating to labor and low income groups. (Report No. 1) Washington, D.C.: National Institute of Labor Education, 1963.

Reiff, R., & Riessman, F. The indigenous nonprofessional. *Community Mental Health Journal,* 1965, Monograph No. 1.

Rein, M. Strategies of planned change. Paper read at American Orthopsychiatric Association, New York, March, 1965.

Riessman, F. New approaches to mental health treatment for labor and low income groups. (Report No. 2) Washington, D.C.: National Institute of Labor Education, 1964.

Rioch, M. J., Elkes, C., & Flint, A. A. Pilot project in training mental health counselors. (Publ. No. 1254) Washington, D.C.: United States Public Health Service, 1965.

Rosenbaum, M., & Zwerling, I. Impact of social psychiatry on a psychoanalytically oriented department of psychiatry. *Archives of General Psychiatry,* 1964, 3, 31-39.

Star, Shirley. The place of psychiatry in popular thinking. Paper read at American Association for Public Opinion Research, Washington, D.C., May 1957.

Szasz, T. *The myth of mental illness.* New York: Hoeber, 1961.

III

COMMUNITY PROGRAMS AND NEW SOURCES OF MANPOWER

6

COLLEGE STUDENTS AS COMPANIONS TO THE MENTALLY ILL[1]

Jules D. Holzberg, Robert H. Knapp, and John L. Turner

Connecticut Valley Hospital and Wesleyan University

EARLY HISTORY

The Companion Program originated as an adjunct to an undergraduate course in abnormal psychology. The senior author had been teaching this course at Wesleyan University since 1949. One of the requirements of the course had been the writing of a term paper, based on library research. In 1957 the senior author was a member of an audience when a group of Harvard students and Dr. Milton Greenblatt of the Massachusetts Mental Health Center visited the Connecticut Valley Hospital to discuss a program of Harvard student involvements in a Massachusetts state hospital, a program that has more recently been described in print (Umbarger, Dalsimer, Morrison, & Breggin, 1962). The Harvard Program consisted of two parts: groups of students involved in ward recreational programs and case aides (students) working with individually assigned patients. As he reflected on the exuberant description by several of these students and the mental health professional (Dr. Greenblatt), it occurred to the senior author that the case aide part of the Harvard program could be readily adapted to the educational goals of the Wesleyan course in abnormal psychology.

In 1958 he offered students in this course the option of engaging in "field work" and writing a paper based on this experience in lieu of the usual term paper. Within this context, field work was defined as a weekly visit by the student throughout the semester to the same chronically ill mental patient for a minimum of one hour. In addition, each student was to meet immediately after his visit with a small group of students (six to ten) who were also involved in this field work experience. The group meeting, led by a psychologist or a psychiatrist, provided an opportunity to assist the students with any problems occurring in their relationships with the patients and to discuss general issues of a practical or theoretical nature dealing with behavioral deviation and its treatment. Approximately three-fourths of the students in the course elected this option. These students were organized into five groups, each led by a mental health professional.

---

[1] The program to be described has been supported by a United States Public Health Service project grant, MH-01499.

A one-semester trial of the program indicated that this type of volunteer work could be significant for the education of the students and also could contribute to the hospital's treatment program. It was therefore decided to continue and expand the program the following year. Its potential educational and therapeutic significance seemed so real that it was decided that the program would not be anchored to the course in abnormal psychology but would be available to any student on campus who wished to volunteer for this activity. Furthermore, it was felt that the program would be most effective for both students and patients if it were structured in terms of a full academic year rather than as a single-semester experience. A planning committee consisting of members of the hospital staff, an interested Wesleyan faculty member, and several students who had been involved in the program during the first year was set up to structure the program formally. It was at this time that the program was labeled "The Companion Program" (Holzberg, Whiting, & Lowy, 1964).

Out of the meetings of this committee, three major objectives of the program emerged: (1) To give patients the extent and kind of personal involvement that is recognized as a vital factor in the comprehensive treatment of chronic mental illness. We saw the Companion Program as one facet of a total rehabilitation program designed to make social relationships less fearsome and more gratifying experiences; (2) To provide a rewarding experience, both intellectually and emotionally, for the students, many of whom would become community leaders in later life. We agreed that students in the program must not be regarded as a source of unpaid manpower. We wanted them to receive a personal, maturing experience that would equip them to deal with their own adjustments to life and conceivably lead some to seek careers in mental health professions (Holzberg, 1963); (3) To boost the morale of increasingly overburdened, often frustrated hospital personnel by bringing onto the wards young, intelligent scholars, full of the social idealism, hope, and vigor of youth.

The program was conceived as one that would require the utmost cooperation between hospital and university. In practice, the hospital has accepted the role of the willing host for the students, welcoming them as real participants in its treatment and rehabilitation program. It accepts responsibility for the students' orientation and educational experiences and maintains professional responsibility for all patients involved in the program. This responsibility is carried through the chiefs of the units in which the students operate and through the professional group leaders who supervise the students.

The university's responsibility is to recruit and organize student participants, a function that the university has delegated to the student body with a faculty member serving as adviser. Recruiting begins during the first days of fall semester with the distribution of brochures and literature on the Companion Program. Interested students are invited to attend a rally at the university during the first week of school to hear a discussion of the program and its benefits for patients, students, and hospital. Students who have participated in the program previously, a professional group leader from the hospital, and the faculty adviser also speak to the students.

Professional group leaders on the hospital staff are charged with maintaining a common philosophy and working out common problems. Therefore, the group leaders meet periodically. They also meet with ward personnel to assess the response of patients.

The role and obligations of a student are defined at the recruitment meeting at the university and at the student's first session at the hospital. His role is defined as that of being a *friend,* not a therapist, to a patient; and within this context, the importance to the patient of reliability and consistency of visits is stressed. Once committed to the program, the student is obligated to spend at least two hours a week (one hour with the patient and one hour in the group) at the hospital during the academic year, except for Christmas and Spring vacations.

The hospital attempts to be as flexible as possible in adapting itself to the time the students have available. The bulk of the students find afternoon visits most convenient, but occasionally we have had an evening group. The actual assignment of students to specific groups, the designation of precise hours to be spent at the hospital, arrangements for transportation, etc. are left to the faculty adviser. Once a group is formed, a student in the group is usually designated as the student leader, who arranges for transportation and other practical matters.

All interested students are allowed to sign up for the program without prior screening. Criteria for effective screening are frankly unknown. While our research may ultimately yield predictors of success, neither the predictors nor the criteria have as yet been delineated. The commitment for a full year screens out the obviously unmotivated student. Emphasis upon friendship rather than therapeutic services serves to exclude some students with the wrong motivation. The students screen themselves informally and effectively; they do not commit themselves to the program until they have made three visits to the hospital. During this period a student can, and occasionally does, withdraw gracefully from the program.

As indicated earlier, a mental health professional is assigned to each group of students. The professional group leader has a three-fold function: (1) Supervision. He supervises the students to make certain that the relationship is one suitable to a "companion." He helps students to understand the relationship and to handle problems that may arise between student and patient. (2) Support. Typically, students require considerable support in dealing with their anxieties and frustrations. Their anxieties are likely to occur during their first visits to the hospital due to false anticipations about patients and feelings of insufficient "training" for the work. Their frustrations occur when their ambitions for their patients stumble upon the reality of chronic mental illness (Holzberg, 1962). This occurs when a patient does not make as much progress as anticipated, or when a patient has shown improvement and then relapsed. (3) Education. During the group meetings, there is usually considerable discussion of general issues pertaining to mental illness and hospitalization. This is likely to occur most intensively during the second half of the year, when the students' anxieties are sufficiently reduced. An attempt is made to keep discussions general rather than to concentrate on the problems, history, and dynamics of specific patients. Companions do not have access to their patients' psychiatric charts, but at the end of the year the group leader may discuss selected data from the patients' records. This is an event eagerly awaited by the Companions because it permits them to get another view about their patients.

The group leader assumes considerable responsibility both for protecting the patient and for making the Companion's experience a positive one. The essential qualifications for a group leader seem to be experience with patients, a dynamic approach to their problems, and a sincere interest in working with students.

Initially, we were under the impression that the success of our program would depend, at least partially, on letting the students themselves choose patients with whom they thought they could become friends. Accordingly, the chief of the unit involved, the nursing supervisor, and the professional group leader selected a group of patients; and for three weeks following the initial orientation period at the hospital, the professional leader, the students, and the patients met at a weekly social hour held on a ward or in a special room of the patients' building. Students and patients mixed freely in the presence of the professional group leader. During these three weeks, the first hour was devoted to getting acquainted with patients in the group situation. Then, during the second hour, the professional group leader guided a discussion on both general issues and the students' interests in specific patients. We believed that these sessions would allay the anxiety of the students, for many of whom this was their first experience in a mental hospital. At the end of this three-week period, each student selected the patient who would be his Companion for the entire year.

We have since discovered that students often prefer to have patients assigned to them, because frequently they feel guilty when they select one patient over another. Therefore, we may now assign a patient to each student with the understanding that the assignment can be changed at any time within the first three weeks.

pants, a function that the university has delegated to the student body with a faculty member serving as adviser. Recruiting begins during the first days of fall semester with the distribution of brochures and literature on the Companion Program. Interested students are invited to attend a rally at the university during the first week of school to hear a discussion of the program and its benefits for patients, students, and hospital. Students who have participated in the program previously, a professional group leader from the hospital, and the faculty adviser also speak to the students.

Professional group leaders on the hospital staff are charged with maintaining a common philosophy and working out common problems. Therefore, the group leaders meet periodically. They also meet with ward personnel to assess the response of patients.

The role and obligations of a student are defined at the recruitment meeting at the university and at the student's first session at the hospital. His role is defined as that of being a *friend,* not a therapist, to a patient; and within this context, the importance to the patient of reliability and consistency of visits is stressed. Once committed to the program, the student is obligated to spend at least two hours a week (one hour with the patient and one hour in the group) at the hospital during the academic year, except for Christmas and Spring vacations.

The hospital attempts to be as flexible as possible in adapting itself to the time the students have available. The bulk of the students find afternoon visits most convenient, but occasionally we have had an evening group. The actual assignment of students to specific groups, the designation of precise hours to be spent at the hospital, arrangements for transportation, etc. are left to the faculty adviser. Once a group is formed, a student in the group is usually designated as the student leader, who arranges for transportation and other practical matters.

All interested students are allowed to sign up for the program without prior screening. Criteria for effective screening are frankly unknown. While our research may ultimately yield predictors of success, neither the predictors nor the criteria have as yet been delineated. The commitment for a full year screens out the obviously unmotivated student. Emphasis upon friendship rather than therapeutic services serves to exclude some students with the wrong motivation. The students screen themselves informally and effectively; they do not commit themselves to the program until they have made three visits to the hospital. During this period a student can, and occasionally does, withdraw gracefully from the program.

As indicated earlier, a mental health professional is assigned to each group of students. The professional group leader has a three-fold function: (1) Supervision. He supervises the students to make certain that the relationship is one suitable to a "companion." He helps students to understand the relationship and to handle problems that may arise between student and

STUDENT-PATIENT ACTIVITIES

While most student-patient activities take place at the hospital, we also allow Companions to take patients into town or on a visit to the university if the chief of the unit approves. While visiting their patients, students may engage in whatever activities seem appropriate to the patients' interests, e.g., talking, walking, playing games, listening to music, reading, etc.

The range of activities in which student and patient may engage are limited only by the interests of the patient and the good taste and judgment of the student. Occasionally an activity seems to violate the latter, as when a student was observed riding with his patient on a motorcycle. But even here it was later learned that the student had merely responded to the patient's comment that he had never ridden a motorcycle.

Once the student has a Companion patient, it is typical for the student to meet his patient in the building in which the patient resides. This meeting may occur on the ward or in the visitors' lounge. The student and patient may have decided during the previous visit how they would spend their time next week, or this is decided on the day of the visit. A student may spend time alone with his patient, or several students and their patients may become a group for that visit.

Exploration of the hospital grounds is a common activity in early visits. Sometimes it is the patient who takes the initiative in orienting the student to the hospital. He may escort the student on visits to the chapel, occupational therapy, the movie house, the library, the greenhouse, etc.

A frequent activity is just talking. To most of our students, this is their most usual mode of relating to friends. This "talking" may occur in the context of taking walks through the hospital grounds, drinking coffee at the hospital canteen, listening to music in the music department, etc. The content of such talks is varied; they may cover areas of mutual interest, how each spends his usual day, their backgrounds, how the patient feels about leaving the hospital, etc. Where the patient's interests indicate it, the student may discuss certain academic areas, as in the case of the student who had a patient who shared his interest in mathematics. Sometimes the student may bring something to the patient, such as drawing materials or a book that the patient has expressed interest in. However, talking is not always a comfortable medium of interchange for many of our patients. This may lead the student to engage in games such as checkers, cards, tossing a ball around outside, playing pool, etc. One student who had a patient who was not a talker found that his patient and he could spend time throwing pebbles at a tree from varying distances. The patient was obviously skillful in this activity; and presumably this demonstration of skill made the patient more relaxed with the student, for he became more talkative on subsequent visits.

Where patients tend to spend much of their daytime hours on their wards, students almost instinctively "pull" to get the patient to leave the ward for the visit. If the patient is too disturbed to leave the ward in the opinion of the ward staff, the student may spend the entire hour with the patient on the ward. Occasionally a patient resists the student's desire to go outside, sometimes out of fear, sometimes out of negativism; but it is a rare Companion experience which is solely limited to visits on the ward throughout the year, even if the patient is residing on a closed ward.

The age and physical condition of the patient also determine the kinds of activities in which patients and students engage. The younger, more vigorous patients can, of course, engage in more active pursuits, whereas the older, more debilitated patients are more likely to enjoy sedentary activities.

Not infrequently students may take their patients to visit the university (Wesleyan is only five minutes by car from the hospital). They may explore the university grounds together, have dinner at a fraternity house, attend a concert together, or meet and talk to a professor, as in the case of a patient who had expressed an interest in anthropology and whose student arranged for the patient to visit with a professor in that department.

Thus, considerable latitude is provided the students in terms of their activities with patients. Very little structure is provided by the professional staff, and it has been our experience that little structure is needed. The sensitivity of the students and their basically good judgment have been apparent throughout the history of the program.

PATIENT SELECTION

Considerable thought has been given to the question of the type of patient to be selected for this program. While the criteria have remained tentative, we are in general agreement that patients for this program should be chronically ill and have minimal involvement with ongoing hospital programs. They should present no symptoms or behavior that would be especially disturbing to the students. They should not be so regressed that they would be more appropriate for a remotivation program,[2] nor so socially developed and capable of tolerating an intense interpersonal relationship that they are ready for formal individual or group therapy with a professional. We believe the patient best suited to the Companion experience is one who has responded to remotivation and is now ready for a social relationship with a relatively benign individual. We are particularly interested in the "forgotten" patient who has minimum or no contact with other hospitalized patients or with members of his community, including his family.

[2] Remotivation is a program designed for the most regressed and alienated patients to remotivate them to enter into the most minimal social interactions with others. Appropriate patients for such programs are patients who do not communicate at all or who communicate incomprehensibly. Patients selected for the Companion Program are not usually at such a regressed state.

No attempt has been made to match student and patient on any variables, including sex and age. It is entirely fortuitous whether a group of patients selected for a group of students happens to consist of men, women, or both. The same applies to the ages of patients, although the bulk of patients selected are older than the students because of the criterion of chronicity. The largest number of patients are schizophrenic.

The goals of the Companion Program for the patient are improvement in his level of social communication, social skill, and social responsibility that would help effect his social recovery and hopefully lead to his discharge. Patients for group therapy are often recruited from those who have been in the Companion Program.

The problem of handling separation and termination is a continuing one. The students are concerned about the effects of these on their patients, but at times more than is justified by the nature of their relationships. We have thought about this problem but have collectively agreed that patients cannot and should not be protected from the realities of living, one of which is the movement of people into and out of their lives. The group leader's task is to help the students carry through separation and termination so that it is not traumatic, either for the patients or for the students. Separations loom as a significant problem twice a year, at the long Christmas vacation and at the end of the school year. We believe that holding a party for patients and their Companions just prior to the Christmas vacation and a picnic just prior to the end of the year serves to allay separation anxiety for both.

From its beginnings at one university, the program has now expanded to students of seven colleges—Wesleyan University, Yale University, Trinity College, Central Connecticut State College, University of Hartford, Hartford College for Women, and St. Joseph's College of West Hartford, Connecticut. Between 100 and 150 students participate each year, including several who have been in the program for two and three years.

This introduction to the program would be incomplete without mention of concerns expressed by some of the hospital staff at the program's beginning. Concerns were expressed that the student-patient encounters would be damaging to patients, traumatic for students, and disturbing to hospital routines. We are pleased to indicate that not one of the hundreds of students was traumatized; on the contrary, as we shall report later, many students apparently go through a quasi-therapeutic experience. Some students drop out of the program, but we are unaware even in these instances of any genuine trauma to the students.

As far as patients are concerned, we are reasonably certain that their friendships with students are experienced as a positive encounter with a deeply committed human being. While a student may occasionally tend to get emotionally overly-involved with his patient, no student has ever been asked to resign from the program. While students often take their patients off the wards, and some of these patients are from closed wards, there has never been a single instance of a patient trying to escape from the hospital.

It is inevitable that some disturbance of hospital routines would result from student involvements at the hospital. Students "unknowingly" impose demands for healthy behavior because they do not reinforce patient pathology. They view the patients in the most humanistic and equalitarian terms. They encourage patients to make demands on the hospital and its personnel. This should inevitably collide with the efficiency of hospital ward functioning. But it is a tribute to the nursing personnel of our hospital that they have been able and willing to adapt to the demands that must eventuate from such a program.

CHARACTERISTICS OF COLLEGE STUDENTS

It is a question of prime pedagogic interest to know if students volunteering for the program represent a self-selected and distinctive body in terms of psychological attributes, or whether they are a typical cross-section of the student population from which they are drawn. Fortunately, at Wesleyan University an extensive testing program involving all students has been in progress for many years. This testing occurs during the week of freshman orientation, and the results have been available to us for comparing students who have volunteered for the program with those who have not. One study (Knapp & Holzberg, 1964) compared such a group of Companion students and control subjects. The control group was a randomly selected sample of nonparticipating students. The two groups were compared on a variety of standard psychological tests. The analysis of the data offered strong refutation of any suspicion that the Companion Program has proven a refuge for the morbid and unstable personalities seeking a bizarre adventure. The evidence is particularly clear that such is not the case.

On the other hand, it is clear that the Companion Program serves as an outlet for certain impulses of human generosity and altruism which has not normally been available to students in the college environment, at least until recently. The civil rights movement, poverty programs, etc. are more recent developments that provide such outlets. So far as our data indicate, the Companions are more idealistic in temper, more capable of generosity, less concerned with personal gain, and more responsive to religious values than their associates who have not elected to join this program. In particular, it proved possible to demonstrate that Companions differed from controls in the structure of their "moral life space." Thus, we were able to show that Companions were more sensitive to the dimensions of goodness and badness and less concerned with power versus weakness than were their corresponding controls. We think it has accordingly been demonstrated with reasonable confidence that the program does not attract significantly unstable or insecure personalities, but rather persons of more than usual moral sensitivity and compassion.

A replication of this study was undertaken with a larger sample, and the results are essentially as reported in the first investigation. As part of this larger study, however, we also explored 13 additional variables (personal, familial, and academic) which might further distinguish Companions from controls. None of the personal and familial variables proved differentiating. Certain academic variables did prove significant. There was a significantly lower incidence of disciplinary action directed against Companions, consistent with the proposition that Companions are distinguished by a higher sense of moral responsibility. Beyond this, Companions more often belong to fraternities and most frequently major in psychology and biology. The first of these findings suggests that Companions more often tend to seek others; the latter finding is understandable because of the pertinence of the Companion Program to psychological and medical science.

Further light may be shed on the character of Companions by observing their declaration of motives as revealed on a questionnaire administered at the beginning of the year. Responses to this questionnaire were sorted under seven headings. The most prominent motives were: to acquire knowledge concerning mental illness and abnormal behavior; to be of service to a person in misfortune and to aid his recovery; and finally, to obtain self-insight. More rarely mentioned were the desire to make friends with unusual persons, to help prepare for an intended vocation, and to obtain personal therapeutic advantage. It may be observed in passing that this hierarchy of motives is generally sustained in rewards reported at the end of the year, though there are a number of significant changes. Briefly, it may be said that the hope to contribute to the recovery of the patient dropped in significance, while the reward of knowing an unusual and different friend appeared to be an unexpected gain from the experience.

We have been keeping careful records of student dropouts from the program (they number between 10%-15% each year) and are currently examining data about these people which will help us to understand more fully the student who starts the program but does not complete it.

EFFECTS ON PATIENTS

Initial attempts to evaluate the program in terms of its impact on patients have rested on questionnaire ratings by students, observations of the professional leaders, and various anecdotal information. A questionnaire study carried out on the first year's Companions offered some basis for considering the experience a significant one for the patients. Clearly, these data are not objective, being based on the students' own perceptions of their experiences. However, they may nevertheless be of some interest to consider. Of the students who responded to the questionnaire at the end of the year, 84% reported that their patients desired the companionship relationship and sought to maintain it. A typical student comment was, "She seems to appreciate my visits and attention." Seventy-one per cent reported that students and patients conversed more freely. Sixty-five per cent reported that their patients showed positive changes in self-confidence. Sixty-four per cent reported greater interest on the part of the patient in his surroundings. A comment of one of the students in this regard was, "She's more interested in the activity of the hospital. She began helping with aged patients in the Infirmary. She is generally more aware of herself and her surroundings. She began corresponding again with friends outside the hospital." Another student reported, "It has brought him out from his withdrawn state. He is first starting to show significant improvement." Positive changes in the patients' personal appearance were reported by 55% of the students, and 48% reported that the patients' social behavior had improved during the year.

The students also reported changes in certain symptomatic expressions of their patients. Forty-two per cent of the students reported that their patients showed improvement in realistic thinking, and 46% of the students reported that their patients showed improvement in their mood, reflected in reduction of depressive indications. Overall, the students considered that 71% of the patients had shown improvement in the Companionship year. Twenty-nine per cent were unchanged. If these findings could be corroborated with controlled investigation, the result would be quite startling, considering the fact that all of the patients were chronically ill and had been in the hospital for a substantial number of years, some for more than twenty years.

Greenblatt (1962) reported that a similar program at Harvard resulted in the release of many patients who were ". . . elderly, chronic, institutionalized people." Kantor (1962), in describing this same study, indicated that 11 of 55 chronic patients who had been in the hospital for at least five consecutive years were able to leave the hospital. The absence of controlled data on a population not associated with college students limits this type of information, but both authors express confidence that the results are attributable to the college student involvements. However, one must note that the onset of college volunteer programs coincides with many changes in institutional policies, such as the Open Door, and with the use of the ataractic drugs, so that it is difficult to evaluate discharge rates without control groups.

More recently we have collected psychological test data in order to compare Companion patients with a group of control patients who were not in the program. A number of psychological assessment procedures have been used, including the Minnesota Multiphasic Personality Inventory, Bender Gestalt Designs, and Draw-a-Person. Of the patients to whom the MMPI was administered, only 14 Companion patients and 30 control patients completed full MMPIs before and after the program. While we cannot be certain that these MMPI performances are representative of the total Companion and control patient populations, we nevertheless believe that it is of interest to report that one clinical scale (Depression) changed significantly from the pretest to the posttest. Companion patients showed a significant decline on this scale. A comparable difference in the same direction on the Paranoid scale barely missed significance. The data on the Bender and Draw-a-Person are currently being analyzed to determine if any significant changes have occurred in our Companion patients on these instruments.

Beyond this, in order to assess the saliency of the Companion experience for the patient, Companion patients have been interviewed after the termination of the Companion year with regard to the importance they attached to their Companions, how much they knew about the student, what they believe the students' motives were for coming, whether and why they would like a Companion the following year, the values to the patient from seeing a Companion, what they expected and how satisfactory the experience was, and their suggestions for improving the program. These data are presently being examined. In addition, professional group leaders have provided ratings on the overall degree of change in the patients seen by their students. These data are also currently being analyzed.

We are now in the midst of collecting data on both Companion and control patients with regard to their ward behavior. Ratings on a hospital adjustment scale were made at the beginning and end of the year by nursing personnel. This scale provides information on three aspects of hospital adjustment: communication and interpersonal relations; care of self and social responsibility; and work, activities, and recreation. In addition, we are examining the extent to which the Companion experience produces changes in the patients' interest in, awareness of, and adaptation to, their immediate environment. Companion patients and control patients were administered a hospital information test at the beginning and end of the Companion year. The test is designed to yield a measure of the extent and nature of a patient's knowledge of the hospital environment. This test has been related to a variety of variables, including patient styles of adaptation to the hospital and discharge rates.

EFFECTS ON STUDENTS

KNOWLEDGE AND ATTITUDES ABOUT MENTAL ILLNESS

Indifference, or something worse than indifference, has characterized society's attitude towards the mentally ill throughout history. While encouraging changes have recently been taking place in official attitudes, it is still disconcerting to observe the continued indifference, if not outright rejection of the mentally ill, by substantial segments of the public. Extensive programs of community education seem somehow to have had less impact on the public than comparable programs concerned with other health problems. Pity may have been aroused, but this has not substantially diminished the public's ostracism or isolation of the mentally ill.

The paucity of results achieved in altering the public's attitudes has recently been examined by the Joint Commission on Mental Illness and Health (1961). This report has detailed a number of ways in which the abnormal personality plays a significant role in determining the public's attitudes of indifference and rejection. The mentally ill are often unpredictable people, and thus they threaten the ordered stability of the community. Furthermore, by their apparent refusal to get along with other people, they create the impression of being unwilling to be fully responsible members of the social community. Finally, the mentally ill patient is frequently unwilling to accept sympathy and assistance because he does not see himself as "ill." He thus turns away from aid and sympathy that may initially have been generously offered. This refusal is experienced by the community as rejection, which leads into a vicious circle of mutual rejection. Considerations such as these help in understanding the strong resistance to change in the public's attitudes in spite of massive educational programs on mental illness.

The need for improved public understanding of mental illness is clear when one considers the cost of the prevalent indifference and rejection to afflicted individuals and their relatives and to society at large. Persons who might live profitably, or at least harmlessly, in a more acceptant community are unnecessarily placed in mental hospitals ("put away," in the popular phrase) or are kept there to little or no therapeutic purpose only because they have nowhere to go where they can be accepted. Employers, fearful of the stigma attached to the label "mental patient," may refuse to hire well-qualified former patients, to the detriment of both their own businesses and the ex-patients' self-respect. At the same time, persons in serious need of psychiatric care may fail to seek it, or to accept it if offered, or to profit from it if forced on them, because of unwillingness to be placed in a class which they themselves fear or despise. Still another consequence of the public's negative attitudes is the difficulty experienced by mental hospitals in recruiting sufficient professional and semiprofessional personnel.

These concerns have led us to examine the question of the impact of the Companionship experience on the attitudes toward mental illness and the mentally ill of those participating in it.

In one study (Holzberg & Gewirtz, 1963), a group of Companion students were compared to a control group of students who had volunteered for other forms of social service activities in the local community, e.g., the Y.M.C.A., Big Brothers, etc. The selection of control students in social service activities was an attempt to make the groups as comparable as possible in terms of social interest. Both groups were administered a questionnaire dealing with mental illness. While to a great extent the questionnaire probed for specific information, it was felt that it would nevertheless reveal certain attitudes toward the mentally ill. The questionnaire was administered at the beginning and at the end of the academic year to both groups of students. The results of the study were rather clear-cut. The two groups, which were not significantly different from each other at the outset, were significantly different at the posttest. The companion group demonstrated that its members had gained in knowledge and positive attitudes from their experience. While the subjects of the study constitute a sampling of a highly selected and limited part of the general population, we feel that its importance lies in the fact that this segment of the population will be occupying positions of leadership in the future. Consequently, the knowledge gained and the attitudes affected by the Companion experience should lead to more constructive approaches in the field of mental illness.

More recently, we have done a further study on possible shifts in attitudes toward the mentally ill. We have used an extensively validated instrument, Opinions about Mental Illness (OMI), which was administered to student Companions and controls at the beginning and end of the Companionship year. A factor analysis of the pretest data yielded six factors: authoritarianism, benevolence, mental health ideology, social restrictiveness, interpersonal etiology, and alienation. While we found overall differences in the levels of the factors between Companions and controls and differences in the two student groups combined from pretesting to posttesting, the analyses do not indicate significant changes in these factors as a function of the Companionship experience. However, separate analyses of every item in the OMI indicate that Companions do change more than controls in their agreements and disagreements with items, suggesting that the Companions show more "stirring up" of attitudes even though the items on which they change do not cluster according to the factorial structure found in the analysis of the pretest data. There was reason to believe that different Companions were changing in different ways, that they were in fact being affected by the experience.

CHANGES IN MORAL JUDGMENT AND SELF-ACCEPTANCE

From the very first year of the program, there were indications that the students were undergoing certain important personality changes that conceivably could be attributed to the nature of their experience. From discussions with students during their hospital visits and from certain written reports prepared by some of the students, we sensed very early that the impact of this social experience transcended mere intellectual enlightenment and involved basic personality growth. Thus, viewed pedagogically, it appeared to us that the program was serving in many cases a more transcendant educational aim than that commonly subsumed under the designation "academic." Involved here, it appeared to us, was a growth of social awareness, empathic range, and self-realization which might be described by the phrase "nonintellective education."

Although numerous personality dimensions seem conceptually relevant to this process, further examination of the students' subjective reports of the kinds of changes they perceived in themselves suggested two foci of research interest—moral judgment and self-acceptance. We designed a study to measure, during the course of a year, changes in these two areas of personality in the group of Companion students and a comparable group of control students (Holzberg, Gewirtz, & Ebner, 1964).

The first instrument administered to the subjects consisted of a scale of moral judgments of our own design. Changes on this scale revealed that the Companions became more tolerant of their judgmental evaluations of sexual and aggressive behaviors. It is of interest that the Companions began the year presenting a picture of greater moral severity than the control group, that they were more disapproving of the behaviors relating to sexuality and aggression. This may reflect the findings of another study showing that religious values occupy a more central role in the philosophies of the Companion students as compared to non-Companion controls. The fact that the Companions shifted toward greater tolerance of sexual and aggressive behaviors suggests that the Companion experience may facilitate the relaxation of initial moral rigidities. Although, on various grounds, one might expect similar kinds of changes in college students from the maturational and presumably broadening effects of the college experience, it is noteworthy that the control group revealed no such change.

On the self-acceptance measure, while it was found that the two groups did not differ significantly at the beginning of the year, the Companions shifted conspicuously toward greater self-acceptance, while the non-Companions showed a slight trend toward less self-acceptance at the end of the year. This latter trend is difficult to interpret in view of the diverse factors which might influence such a broad variable in the normal course of the year's activity. This change might be a reflection of heightened tension and anxiety concerning the approach of the final examination period, which coincided with the time of the retesting. However, regardless of the cause of this trend in our control group, it is noteworthy that the Companions, exposed to the same general campus environment, exhibited a significant opposite change.

CHANGES IN INTROSPECTIVENESS

Companion students and controls were evaluated on a preprogram-postprogram design for changes in their level of anxiety and the extent to which they utilized repression as measured by scales of the Minnesota Multiphasic Personality Inventory. While there were no significant differences between the groups in terms of changes on the repression scale, there was a significant tendency for the Companion students to manifest increased scores on the anxiety scale. Because of the nature of the items used to assess anxiety, this latter result has been interpreted by us as a change in greater introspectiveness on the part of the Companion students.

STUDENT EVALUATION OF THE PROGRAM

At the end of the first year of the program a questionnaire was administered to the participating students. All of the students indicated they had grown in their knowledge of mental hospitals and the consequences of hospitalization. Ninety-one per cent stated that they had become less anxious working with patients during the course of the year. Ninety per cent felt they had grown in their understanding of mental illness, its causes, and treatment. Eighty-one per cent said that their feelings about patients had changed: they had acquired the ability to see patients as sick people who were worthy of support and aid rather than derision. Implicit was the recognition of the prejudices that they had brought into their encounter with patients. Eighty-four per cent reported that their feelings about mental hospital personnel had changed, and that they understood better the nature of the problems experienced by these people. Many also reported better understanding of the various mental health professions.

A number of the students volunteered statements alluding to the multiple values of the experience for them: "This Program is a good and effective method of letting others know the problems faced by mental hospitals today. I sincerely hope that it reaps a reward in the future generation." "I feel that the companionship I had this year was more or less one-sided. I gained terrific insights into the mental hospital complex, its patients and its problems." "I feel quite strongly that all graduate students in psychology, and maybe even all majors in psychology, should take part in the Program. It is a very valuable experience." "The Program has caused me to take a more objective view of my own emotional problems." "Keep up the Program. For me, and I think for most everyone, the experience has been most rewarding." Ninety-seven per cent of the students felt that their experience had contributed to their personal growth. There has been the occasional student who has expressed the opinion that being a Companion has been his "most valuable college experience."

During one of the recent years of the Companion Program, students were administered another questionnaire at the end of the year designed to determine how they assessed their Companion experience retrospectively. The responses were factor analyzed and five factors were tentatively identified, designating different styles of outcome that characterized different groups of students. The first factor defined a style of outcome characterized by growth in knowledge about the hospital and its treatment program. Here the knowledge was impersonal and the prime reward was intellectual. The second factor defined a style of outcome characterized by desirable changes in life outlook and rewarding personal gains associated with a feeling on the part of the student that he had developed a relationship of friendship with the patient. The third factor described a style of outcome which was also characterized by genuine friendship with the patient, but in this case it was accompanied by emotional stirrings of a deep nature. The fourth factor defined a style of outcome characterized by an intense and indignant concern with the patient's misfortunes, leading to a somewhat more pessimistic life outlook but with the student feeling that there had been gratification of altruistic motives. The fifth factor defined a style of outcome characterized by the acquisition of personal knowledge about patients and how it must feel to be a patient, combined here also with the feeling that altruistic motives had been gratified.

We are currently studying systematically changes that have occurred in the basic life values of Companions.

FOLLOW-UP STUDY

A questionnaire was mailed to all graduates who participated in the Companion Program. An unusually high return was achieved. The questionnaire sought data on how the alumni assessed their Companion experience retrospectively. While there were considerable individual differences in the way in which they described their Companion experience, the overall responses of the alumni could be summarized as follows. Those who responded indicated that they had had feelings of solicitude toward their patients, a desire to help them, and curiosity and interest in the patient's case. They denied having been tempted to laugh at the patient or having been repulsed by the patient's illness. They also denied any fear of viewing the manifestations of mental illness. While admitting to some general anxiety on their initial contacts with their patients, they denied having had any fear of self-revelation or any anxiety about their own mental health or the possibility of mental illness. They expressed anguish over the waste of human potential in the patients and denied that the patient was responsible for his condition or responsible for causing suffering to others. They described their relationships with their patients as having been a unique experience for them (the alumni). A substantial number indicated that their Companion experience had confirmed their vocational interest in careers related to mental health—notably in psychology, psychiatry, and social work; more rarely in the ministry and legal profession. A small though important number expressed dismay and indignation at the state of psychotherapy and the treatment of mental disease.

While these general findings contain few surprises, they do generally confirm the high value which Companions tend to attach to the Companion experience in retrospect. A more penetrating analysis, however, is contained in the identification of certain modal reaction styles as contained in this questionnaire. From this analysis, four definable reaction styles emerged.

First, there is the "friend," namely, the Companion who shows little anxiety upon entering the program, is dominated by amiable intentions, has little hope of vocational gain, and, in the main, describes his experience as easy and friendly. The second reaction type may be described as the "soul-searcher." This type of person confesses to his own problems and anxieties, admits his hope for gaining personal insight, and avoids an easy optimism in his estimate of the gravity of mental illness. The third reaction type might be described as the "vocation-seeker," or better, "vocation-finder." In any event, this person tends retrospectively to indicate the importance of the program in confirming or directing him toward his present vocational interests or pursuits. This individual appears to be relatively objective in his concerns and practical in his orientation, devoid of the quick amiability of the first type and the anxious preoccupation of the second. Finally, our fourth factor yields a hypothetical type that might be designated as the "altruist." The prime motive of this type, as might well be surmised, is the ambition to alleviate suffering and contribute to the healing of the patient. Such persons show a combination of empathic involvement combined with moral indignation unparalleled in the other three types.

This mode of analysis is a salutary correction to the conception that general trends in our data reveal the whole story. Indeed, it would appear that the Companion Program offers a wide variety of meaning to different persons, depending upon their qualities at the outset, the circumstances that impel them to enter the program, the type of patient to whom they are assigned, and the type of direction and supervision they receive during the course of the Companion year. The manner in which the reported experience of the Companion is related to these and other dimensions is the subject of current inquiry, but it may be observed in passing that we can already demonstrate that the age and sex of the patient are meaningfully related to the four styles of experience reported in this follow-up study. Thus, for example, individuals assigned to younger male patients more frequently report the soul-searching attitude, while those with older women as Companion patients rarely show vocational trends in their Companion experience. In brief, the recognition of pluralism in reaction styles as a function of motives for entering the program, the quality of the experience obtained, and its retrospective evaluation is important to a full comprehension of this enterprise.

CONCLUSION

The Companion Program, after eight years in operation, is viewed as a significant contribution to the treatment of a patient population whose inertia and alienation tend to result in their remaining outside the mainstream of hospital treatment programs. It is judged to provide a "therapeutic" human relationship of intimacy and consistency for a select group of patients who, if left to their own devices, would assiduously avoid it. While we are currently theorizing about the basis for the therapeutic value of this experience for the patient, we have recognized one important therapeutic "attitude" the student brings: blind to the patient's psychopathology, he relates to the patient as another human being and not as a phenomenon of mental illness. It has been suggested that the student may be the only person with such an attitude who encounters the patient, a patient who has withdrawn and insulated himself from human relationships which he feels will be as hurtful as those he has endured in the past.

The program is also viewed as a significant contribution to the non-intellective education of college students. Students participating in the program undergo changes in personality not unlike those that have been observed and reported as occurring in psychotherapy. They show a reshuffling of attitudes about mental illness with a modal shift toward more sympathetic and realistic understanding of this problem area; they demonstrate a modal shift toward greater self-acceptance, greater tolerance for heterosexual and aggressive behaviors, and a heightening of introspectiveness.

It seems to us that the Companion Program has brought together two individuals who normally would have a rare or transient encounter—the patient, often lost in despair and retired from life; the student, a younger person at the height of social idealism, courage, and optimism. What has emerged thus far in our work is that the relationship between these two has had many beneficial consequences for both. The patient seems to borrow some of the optimism and courage of his Companion and the Companion gains wisdom and charity that is personally enlarging. Above and beyond this, it has opened another channel of communication between the hospital and its patients and the outside community.

REFERENCES

Greenblatt, M. A role for the voluntary organizations in the work of mental health institutions. In *College student companion program: Contribution to the social rehabilitation of the mentally ill.* Hartford, Conn.: Conn. State Dept. of Mental Health, 1962, Pp. 10-18.

Holzberg, J. D. The significance of the companionship experience for the college student. In *College student companion program: Contribution to the social rehabilitation of the mentally ill.* Hartford, Conn.: Conn. State Dept. of Mental Health, 1962, Pp. 39-48.

Holzberg, J. D. The companion program: Implementing the manpower recommendations of the Joint Commission on Mental Illness and Health. *Amer. Psychol.*, 1963, *18*, 224-226.

Holzberg, J. D., & Gewirtz, H. A method of altering attitudes toward mental illness. *Psychiat. Quart. Supplem.*, 1963, 37, 56-61.

Holzberg, J. D., Gewirtz, H., & Ebner, E. Changes in moral judgment and self-acceptance in college students as a function of companionship with hospitalized mental patients. *J. consult. Psychol.*, 1964, *28*, 299-303.

Holzberg, J. D., Whiting, H. S., & Lowy, D. G. Chronic patients and a college companion program. *Mental Hospitals*, 1964, *15*, 152-158.

Joint Commission on Mental Illness and Health. *Action for mental health*. New York: Basic Books, 1961.

Kantor, D. Impact of college students on chronic mental patients, and on the organization of the mental hospital. In *College student companion program: Contribution to the social rehabilitation of the mentally ill.* Hartford, Conn.: Conn. State Dept. of Mental Health, 1962, Pp. 28-38.

Knapp, R. H., & Holzberg, J. D. Characteristics of college students volunteering for service to mental patients. *J. consult. Psychol.*, 1964, *28*, 82-85.

Umbarger, C. C., Dalsimer, J. S., Morrison, A. P., & Breggin, P. R. *College students in a mental hospital.* New York: Grune & Stratton, 1962.

7

PILOT PROJECTS IN TRAINING MENTAL HEALTH COUNSELORS

Margaret J. Rioch

The Washington School of Psychiatry

In 1958 when the projects described in this chapter were first envisioned, community psychiatry had not yet become a popular concept. But a trend in the mental health field toward thinking in terms larger than individual problems had long been operating in people's minds, even when it was not fully conscious. In line with this trend, the Pilot Projects in Training Mental Health Counselors attempted to demonstrate that two large-scale community problems brought together could help to solve each other. When we think in community terms, we are aware that no problem is isolated and that the solution of one problem may bring about even greater difficulties in some other area. In one sense this is unavoidable and apparently inherent in human society, which seems to have within itself some built-in obstacles to attaining Utopia. But in a less fundamental sense, it is avoidable. We need not and should not concentrate on the solution of one problem in isolation without regard to the consequences in other areas.

For example, it is conceivable that we might solve the shortage of mental health professionals by making this field so attractive that all the people who would ordinarily go into general medicine, nursing, teaching, etc. would become psychiatrists, psychologists, and social workers. Obviously this would not be a boon to society. Even the legitimate recruitment of college students to go into psychology and of medical students to go into psychiatry could be looked upon as increasing the shortage of teachers and general practitioners, and thus not helpful in the solution of the community's total problem. If we could find a reservoir of manpower which is not at present exploited, then we should be paying Paul without robbing Peter. Women in general, and mature women in particular, represent one of the chief underused groups in the labor market of the United States. Although large numbers of women are employed, they occupy the lower-level jobs in the labor force. This may be appropriate for some, and in accordance with their education and skills, but it is a gross waste of the talents of others.

In recent years the idea of "second careers" for women has become increasingly popular. While keeping in mind that all students should not be forced into the same mold, those responsible for the education of women are aware that the majority of girls want first and foremost to marry and have children; and this is usually their first career. But also, and especially if they are of above-average intelligence, they want something else. They want it particularly after the children no longer provide them with a full-time job and a reason for existence. At this time in their lives they are ready psychologically for a second career. But more likely than not, their way to it is strewn with obstacles. They have not been adequately prepared for this phase of their lives. Most young girls tend to overlook the fact that they will probably live beyond the age of thirty and that they will probably outlive their husbands by about seven years. Thus they are often taken off balance by the psychological "change of life" which occurs when the center of interest which has been occupied for fifteen years or so by small children is left unoccupied. They are ill prepared for the kind of mild depression and sense of worthlessness which settles in when they are faced with a good chance of forty more years of life and not enough work to do to fill each day. To be sure, there are ways of curing or obscuring this depression. There are trips, clubs, hobbies, volunteer activities, and grandchildren. These are fine if they work. Women who are particularly vulnerable to this kind of depression are not necessarily the neurotic type. They may be intelligent, competent, healthy, and energetic. When their abilities are not being used to the full, they suffer as anyone suffers who does not find an appropriate outlet for his talents. A typical woman of this kind married early, before she got any specialized training or work experience in a field that might represent a long-term interest. Or perhaps she did have training, for example, in biology. After fifteen years out of the field, she feels rusty and unable to compete with young people fresh from school. Or perhaps, and this is a frequent phenomenon, her interests have shifted in the fifteen years of preoccupation with family affairs from biology to interpersonal relationships. What is she to do then?

If women like this could be mobilized to use their full energies and capacities in the mental health field without having to spend an inordinate and discouraging length of time in preparation, we should have a significant addition to the manpower pool and at the same time a marked increase in the health and welfare of the women themselves. There might even be a few men who in their forties found that they were in the wrong jobs. If they could afford to do it financially, they might be happier to switch over to the mental health field. There would probably be only a small number of men who would have the inclination, the talent, and the financial security to do this. But there is a very large number of mature women who have all three. In addition they have the advantage of their life experience in the field of human relations. If they have had their eyes open at all, they have had the equivalent of several courses in child development, to say nothing of family dynamics and the problems of adolescence. This does not mean that their knowledge is optimally usable without training. But it does mean that they start with a tremendous advantage on the experience side of the ledger over the young student who has to gain his knowledge by less intimate, less constant, and less participant observation.

The question is sometimes asked why should special programs be set up for such women? It may be agreed that they represent an excellent reservoir of manpower, but why not encourage them to go into one of the traditional professions, in particular social work, since that is the one which requires the least number of postgraduate years to complete? The answer to this question is twofold. First, traditional professional training programs, until very recently, have preferred the young student just out of college to the mature woman who has not held a job or taken a course for the past fifteen years. Traditional training has been difficult for the mature woman to obtain, even when she sought it vigorously, and it is still not always open to her. Second, she has often been reluctant to seek it out, even when she was ready and eager to do something with her talents. The reasons for this are complex.

One very practical reason is the requirement in most traditional professional training programs of at least one year of full-time work. The women with whom we are concerned do continue to have domestic responsibilities of varying degrees. Their children are often still living at home, even though they spend most of their days in school. If the mother tries to handle a full-time course of study with little domestic help, she may find that her energies are too depleted to fill the decreasing but still present emotional and practical needs of her children, to say nothing of those of her husband. This is something which varies enormously with individual women and the individual situation. Some are so efficient or so blessed with cooperative husbands and able domestic help that it is no hardship to study or work full time. They should by all means do so. But many, many others who could give a generous half time find the requirement of full time more than they can carry.

Another reason has to do with the educational prerequisites of the traditional training programs. These include a bachelor's degree and sometimes particular undergraduate courses. There are many mature women who either did not attend or did not finish college who are today as alert and as well educated in a general sense as are their contemporaries who did. They are often children of the depression. If there was any money left for college tuition, it was for the boys of the family. With early marriages we are building up again, for different reasons, a large number of women who did not graduate from college but who, at around age thirty-five, will be looking for interesting work but without the formal prerequisites for entering traditional graduate training. Faced with the prospect of four years or more of study, much of which she finds dull and irrelevant to her purposes, the mature woman often decides that life is too short to spend such a large proportion of it in preparation for a new career.

A third reason for reluctance on the part of the mature woman to enter traditional training is her recognition that she is out of practice in ordinary academic work and that she will be competing with bright youngsters who are very much in the groove and know about the latest theories or the latest experiments. It is not uncommon that women with excellent grades in college and excellent capacities for mature graduate work do badly on the graduate record examination. It is still less uncommon that they fear they will do badly. There are two seemingly opposite, but closely related, attitudes which women express about going back to school after a fifteen-year pause. One is an attitude of fearful timidity and apprehension about not being able to keep up. The other is an attitude of superiority to the ritualistic requirements that are not strictly relevant to what is necessary for the tasks they want to undertake. Young students gripe about rigid requirements which seem to have as their purpose nothing but being part of an obstacle race on the way to high grades and diplomas, but they are used to them and grumblingly they plough through them. Mature women who have enjoyed a place of importance and authority in the family and of prestige in the community, through either their husbands' positions or their own volunteer activities, are reluctant to put themselves in the position of having to do whatever teacher says, especially when they consider it stupid. Thus, many women continue in tasks which use only a quarter of themselves rather than risk the humiliation of failure or of subservience. It is easy to object that such women are cowardly or lazy or both and that they would be no great addition to the mental health field. In the extreme case this is true. But there are many, many people in whom these factors operate just sufficiently to keep them away from the competitive professional schools but not to such a degree that their effectiveness would be impaired. In fact, a touch of timidity and self-doubt, a touch of refusal to follow rules for the sake of rules, are qualities which may be quite desirable in a counselor or therapist.

For all these reasons, then, it is important to establish nontraditional programs which will train mature women (and perhaps others as well) in a minimum of time to do the jobs which need to be done in the mental health field.

The two nontraditional pilot projects to be described here trained a total of sixteen women to be "Mental Health Counselors." This designation did not fill any of those responsible for the projects with enthusiasm, but no one could think of anything better. The term seemed to have the advantage that it could be an umbrella, applicable to many special kinds of counselors and to varying degrees of competence.

In 1960 the first Pilot Project in Training Mental Health Counselors was begun at the National Institute of Mental Health (Rioch, Elkes, & Flint, 1965). The two principal investigators were Dr. Charmian Elkes and the present author. Dr. Arden A. Flint was also a major participant in the program. The project was an experiment to determine whether and to what extent mature, intelligent women with no previous special preparation could be expected to do therapeutic interviewing after two years of part-time training. There would have been no need to demonstrate that they could be kindly hospital visitors. The question was, what would they do if they were sent into a mental health agency to work, like the other professional staff members, with people who complain of anxiety, depression, compulsions, or inability to study, hold a job, marry, or get along with anyone? In other words, could they take responsibility for working therapeutically with patients who had already found the advice and comfort of friends and family to be insufficient and who needed more professional help?

The project staff did not suffer under the illusion that in less than two years of training they could turn out full-fledged all round psychotherapists equipped to deal with any and all psychiatric problems. The idea was that we could train mature people in a short time to deal with a selected population. While giving a broad basis of understanding of psychodynamic principles, we would limit ourselves in practice to one kind of patient, for example, to one age group. If there had been no special determining factors in the situation in which we found ourselves as a staff, we might have thought of training for work with children, or with physically handicapped people, or with young parents, or with any number of other groups of people characterized by a particular age or situation or kind of problem. As a matter of fact, we were limited first, by our own experience and interests and second, by the external situation. Our first thought was to train for counseling with college students. This seemed like a relatively easy task, appropriate to a first experiment. If we had been in a university setting, this might indeed have been the best way to begin. But geographical and transportation factors made it difficult for many college students to visit the NIMH Outpatient Clinic. We persisted in our intention to concentrate on adolescents, however, and broadened our intake requirements to include high school students. Since in the case of these younger patients, the parents usually either had to be seen or wanted to be seen, we soon had a case load of middle-aged people along with the younger ones. Other adults also made use of the service. Thus, without actually intending it, we broadened the scope of our experiment to include a very wide age range from fourteen to sixty.

We also had in mind in the beginning to limit the patients to those with minor emotional disorders. But this, too, turned out to be unrealistic and impossible. Patients with minor disorders are hard to find. Those who sought out our services at the NIMH Outpatient Clinic presented by and large quite serious problems. We did attempt to screen out those who were overtly psychotic, or suicidal, and those who acted out in grossly antisocial ways. But in the agencies in which the students were placed for part of their training, we had no real control over the selection of patients, and even very extreme cases were occasionally encountered. The diagnoses of the patients seen under our own supervision ranged from "adjustment reaction of adolescence" to "borderline schizophrenia" and "psychosis in remission."

A third kind of specialization which we had thought to impose upon our students was that we did not intend them to be diagnosticians or to do intake interviews. At NIMH one of the staff consistently saw all patients initially. But, again, in some of the community placements, initial interviewing was part of the students' job; and we therefore gave some consideration to this in the course work of the second year.

The experiment was designed, then, to show whether and to what extent mature women could be trained within two years, less than full time, to function as psychotherapists in certain limited situations. The limitations which we envisioned in the beginning were widened considerably before the program was over. At the end of the training period, the question was whether they could work adequately under supervision as therapists in mental health agencies such as community clinics with adolescent and adult outpatients.

There was one limitation in the experience and training of our students which was not mentioned in any of our published reports on the project. This was the fact that most of the patients seen by our trainees during their training period were middle-class people from suburban Maryland or from the almost suburban areas of the District of Columbia. This was not consistently the case. Some of the students worked for a time in agencies dealing primarily with the underprivileged, such as the Juvenile Court and the Federal Probation Service in the District of Columbia. A few people of minimal educational and occupational level found their way to the clinics where the students worked. But these were the exception rather than the rule. In our reporting of the numbers of patients, their ages, diagnoses, etc., nothing was included about class orientation. This is an interesting omission. It did not occur to any of us on the staff to make particular note of this factor or to consider its significance in the monograph which we wrote together. Today, only three years after the project was written up, it would be impossible to overlook this. In retrospect it seems that in this oversight we failed to mention one of the factors which contributed to the success of the program. We of the staff were a middle-class group working with middle-class students who were working by and large with middle-class patients. The principal instructors in the program had had most of their own experience with middle-class patients. We were teaching a very homogeneous group of students to work in a very familiar world, the world which we ourselves knew best. To what extent this limitation can be overcome is a matter for further experimentation. It was explored to some extent in the second pilot project in training mature women.

The second pilot project, begun in February, 1964, and completed in February, 1966, used similar students but in a different task. The question here was whether mature, intelligent women could be trained in two years to counsel effectively with mothers of young children. The task was envisioned as a preventive one. If emotional problems could be nipped in the bud in infancy or early childhood, there should be less trouble for all concerned later on. Whereas the middle-class mother has the pediatrician, the child psychiatrist, the nursery school teacher, and other experts all within her ken and within her reach, the lower-class mother is often without resources for information and counsel. The idea of using the experience and talents of women like those in our first project, augmented by training, to produce counselors with a specialty in Child Development who would work primarily with underprivileged mothers originated with Dr. Reginald Lourie, Chief of Psychiatry in the D.C. Children's Hospital. Under an NIMH grant, the D.C. Children's Hospital Research Foundation and the Bureau of Maternal and Child Health of the D.C. Department of Health sponsored a second two-year training program with Dr. Lourie as Director and the present author as Project Administrator.[1] Executive Training Director was Mrs. Margaret Stolzenbach, one of the graduates of the first pilot project.

Recruitment and selection procedures in both projects followed similar patterns. Community leaders, women's associations, PTAs, church groups, college clubs, and other organizations were informed that the programs were about to take place. Potential applicants were warned that these were experimental programs with no assurance of future employment, even if the training were successfully completed. In spite of this, there were approximately fifty serious applicants for the first project and one hundred for the second. Recruitment was by far the easiest aspect of both projects and demonstrated that programs of this nature fill a real need on the part of a large number of women.

Selection was a more difficult task. In both projects eight students were to be selected. This number proved to be a good one for forming a group and did not make excessive demands on staff supervisory time.

In both projects the people chiefly responsible for selection were also instructors in the program. We found this to be desirable in that the students thus selected were likely to be congenial with their instructors. Furthermore, the instructors felt a special responsibility for those whom they had themselves selected. In both programs the instructors were well satisfied with the students. There is no way of knowing, however, whether the chosen candidates were actually the best of the applicants.

In both programs each applicant was required to write an autobiography of about 1,500 words, in which she was to tell not only the major facts of her life but also how she saw her own development. She was then required to participate in some group procedures. This meant that groups of eight to ten applicants assembled to spend four or five hours with two or three staff members, who observed the applicants as they discussed several topics and asked whatever questions they liked about the program. One task required of each group was to discuss a particular question and come up with a consensus. Another was to discuss a tape-recorded interview to which all had just listened. In the second project a task was introduced at the suggestion of one of the graduates of the first which proved to be both enlightening to the observers and helpful to the applicants. This was to discuss how they would think and feel and what they would do if they were rejected. They all knew that the great majority of applicants was bound to be rejected, and the task provided them with an opportunity to air their feelings about this. It also provided the observers with an opportunity to see the kind and degree of defensiveness which each applicant showed.

---

[1] Dr. Samuel Schwartz, Chief of the Bureau of Maternal and Child Health of the D.C. Health Department was Co-Director of the project. During most of the first semester the project administrator was Mrs. Minerva Boomer, who withdrew from the program for personal reasons. The other major instructors were Dr. Hillary Millar and Dr. Allen Marans.

On the basis of the autobiography and the group sessions it was possible to eliminate over half of the applicants. The others were seen in individual interviews, usually by two different interviewers on separate occasions. In the first project we also administered psychological tests. These were omitted in the second project because they did not seem to add sufficiently to the other techniques to warrant the large investment in time required for their administration and adequate interpretation.

The group meetings held in advance of any individual interviews not only saved time in eliminating many applicants but also made the subsequent individual interviews more meaningful. The candidates came to the individual interviews not as strangers, but as people who had already had some contact with the interviewer. Furthermore, it was particularly important to know how these potential students would function in a group because during the training they would be together a great deal and because their behavior with co-workers in community settings would be crucial in their being able to function effectively.

In both programs we were looking for the same kind of person. We wanted a woman whose youngest child was already in school and whose family was willing to have her become involved in what would potentially become a new career, even though it would not necessarily imply full-time work. We asked specifically that applicants be able to schedule flexibly twenty hours a week outside their homes during the training years. We needed women whose families were geographically stable so that the training would be completed and some follow-up could be carried out. We wanted people of good general intelligence who were well-informed, conscientious, reliable, reasonably stable, and able to get along well with others. We looked especially for those who were undefensive and unpretentious, with a sense for psychological subleties. We were very little concerned with where or how they had obtained their formal schooling.

In both programs the average age of the successful candidates[2] at the time of selection was between forty and forty-four. One was widowed; all the others were living with their husbands. All had children; the average number was between two and three. Their husbands were all either professionals, executives, or in upper management. Four of the candidates in the first group and three in the second had had more than two years of psychoanalysis or psychotherapy. Six in the first group and all eight in the second had had previous paid employment.

---

[2] The students in the first project were Jane Donner, Anita Gamson, Leslie Hogeboom, Mabel Mango, Margaret Reid, Alison Sharpe, Lois Showalter, Margaret Stolzenbach. The students in the second project were Caroline Birnberg, Elizabeth Harper, Margaret Howard, Helen Larson, Ann Salzman, Joanne Schulman, Shirley Seeman, Minna West.

The students in both programs were from quite similar middle-class backgrounds, but there was one difference in formal educational level. In the first project all the students were college graduates; three had advanced degrees. In the second, three of the eight had begun but had not finished college; one had an advanced degree. In the first project it had not been our considered policy to reject noncollege graduates. It had simply happened that the applicants whom we thought to be the best ones for our purposes all had bachelor's degrees. It did turn out to be an advantage in seeking placements and employment for them to be able to say that they were all college graduates, since this not only filled certain bureaucratic requirements but also carried with it the implication of a certain level of intelligence and sophistication. In the second project we again had no fixed policy, but we did welcome the opportunity to test our hypothesis that a bachelor's degree is not a necessary requirement for excellent performance in this field. The three students who had not finished college had more than made up for their lack of formal education by wide reading and inquiring attitudes, so that they were not distinguishable from the others in degree of intelligence, sophistication, or general information. During the training period the differences in number of years of schooling were quite irrelevant; in relation to employment it became another matter.

The two projects will be discussed separately with regard to training and subsequent employment, since the pattern and purpose were different for each.

In the first project the training program consisted of practical work and supervision at the National Institute of Mental Health; practical work and supervision in community agencies such as mental health clinics; observation of individual, family, and group therapy; lectures and seminars. These last included courses on personality development, adolescence, family dynamics, and psychopathology, as well as practical case-seminars.

The training was narrow but intensive. It was sharply focused on psychotherapy, and all other instruction was subsidiary and related to this focus. This differentiates it from training for social work, psychology, and psychiatry. Members of all these three professions engage in psychotherapy, but their education includes many other things. Our training was focused on this one goal. We did not try to make any sharp, or even dull, distinction between psychotherapy and counseling, but we tried to help our students to respond authentically and therapeutically without reference to any particular system and to go as far as they could go in understanding the patient and the dynamics of the therapeutic relationship. The students were taught explicitly that there is no one right way to do therapy since it is an integral function of each one's personality. They were also taught explicitly and allowed to see with their own eyes and hear with their own ears that their instructors were quite fallible and that they conducted interviews which were far from perfect. They could learn this by watching us through one-way screens and by listening to tape-recorded interviews. One of their instructors, early in the program, gave them something of the flavor of a continuing case-seminar by playing for them and discussing with them recorded interviews he was having with an adolescent boy. This was a case which was not going well, and he purposely let them in on his puzzles and struggles with a difficult patient. Participating in the program were psychoanalysts, psychiatrists, psychologists, and social workers, all of whom thought in dynamic terms and held quite broad, undogmatic points of view. No one was an evangelical disciple for a particular school of thought. Eleven people altogether had some part in the instruction. This sounds like a huge staff but was actually roughly the equivalent of two full-time people.

Since we expected our students to be primarily practitioners, it seemed to us obvious that the training should be first and foremost practical. The actual work of interviewing began for them within three weeks of the start of the program, before there was any formalized teaching of theory. We wanted them to build up their concepts on the basis of concrete experience and not to try to fit their experience into predigested concepts. We thought that an initial theoretical indoctrination might result in "psychologyzing" or automatic responses, whereas we wanted our students to listen to each patient as a unique individual rather than as a member of a diagnostic classification. We wanted them especially to be aware of their own emotional reactions to the patients. Therefore, we put little stress on theory and postponed any systematic teaching of it until the second year.

It was part of our philosophy that the teaching was to be nonteaching or unteaching. We were going to plunge the students into the waters of confrontation with another person and let them find out for themselves how to keep afloat. Swimming strokes could be perfected later and each student was to have her choice as to which stroke she would prefer. But there were going to be plenty of observers around to rescue both patient and student in case of need. As a matter of fact, it never happened that a patient had to be rescued from a student.

The practical work of interviewing patients, which was done both in the NIMH Outpatient Clinic and in various community agencies and institutions, was usually on a once-a-week basis. All the interviews at NIMH and many in the community placements were tape-recorded. This permitted the supervisors to know exactly what was going on; and in the beginning, a part, at least, of each interview was listened to by one of the instructors. Later on, as the number of interviews by each student increased, this was obviously impossible; but throughout the program, the two principal instructors took home tapes and listened to them over weekends. Discussion of the tapes took place in both individual and group sessions. Taping occurred from the very beginning and was taken so much for granted that it almost seemed as if an interview was incomplete if it were not taped and shared with fellow students or an instructor.

The total program and the students in it were evaluated in a number of different ways, of which only two will be mentioned here. At the end of the first year two series of the students' tape-recorded interviews were sent to be assessed by four raters from outside the Washington area who, without knowing anything about the program or the background of the trainees, agreed to do blind ratings on a five-point scale of the tape-recorded interviews and of the trainees' autocriticisms of the interviews.[3] The ratings averaged in the middle range of the scale, which represented satisfactory performance.

At the end of the second year a panel of three outside examiners was invited to come to the NIMH for three days to evaluate the program. They were Dr. Lotte Bernstein, Director of the Child Guidance Clinic in Louisville, Kentucky, and a former member of the Berlin Psychoanalytic Group; Dr. Robert Gibson, Medical Director, Sheppard and Enoch Pratt Hospital, Towson, Maryland; and Dr. Julius Seeman, Professor of Psychology, George Peabody College for Teachers in Nashville, Tennessee. The examiners listened to a taped interview by each trainee, read a case report, and examined each one for about an hour. Each examination included role playing of a patient by Dr. Seeman, while the trainee was the therapist. The ratings of the trainees by the examiners were gratifyingly high, as was also the degree of agreement among them. They stressed particularly five points.

First, they were impressed by the degree of commitment to the work, which they felt to be greater in this group than in the average professional group.

Second, they found in these women a striking lack of defensiveness which they attributed to the training. (We of the staff thought that this resulted in part from the early and consistent exposure of themselves to us and to each other through the discussion of the tape recordings and in part from our own exposure of ourselves to them.)

Third, they stressed what they felt to be a strong point in the training, namely that "it kicked over the traditional traces of giving a long string of academic work ahead of time and then building up to a little bit of practice." This program gave a great deal of practice first and later a little theory so that the trainees built up their abstractions on the basis of concrete experience.

Fourth, they thought that the women had a strong sense of group identity which had served them so far and might continue to do so in place of a conventional professional "union card."

---

[3] We are indebted to Drs. Roy R. Grinker, Jr., Leroy P. Levitt, and Melvin N. Seglin from the Michael Reese Hospital, Chicago, and to Miss Nea Norton, Assistant Professor of Psychiatry, Yale University, for their help in this part of the evaluation.

Fifth, they were struck by a fact which the women themselves stressed, namely, that they did not have to rely on this program and on their success in it for their major sources of security either economically or psychologically. They had their families and their places in the community quite apart from the success or failure of the project. This seemed to everyone to be an advantage.

Immediately upon graduation every one of the students was offered at least one job. Most of them were in agencies or institutions in which they had had placements during the training period. During the first year, four were employed in mental health clinics; two in hospitals; one in a school; one in a college. All were engaged in therapeutic interviewing of patients. Since then, five have changed to other jobs which were more desirable in terms of money, location, or kind of work.

In March, 1966, almost four years after their graduation, all eight of the original students are still employed in the greater Washington area. All are working at least half time; six are working full time. Five are employed in a mental health clinic or center; one on an NIMH experimental ward; one in a university counseling center; one in a college. Most of them, encouraged and often urged by the agencies where they are employed, have broadened their spheres of activity. To their original training in individual therapy with adolescents and adults, they have added group therapy and child therapy, intake work, administration, teaching, and consultation. Most of them have participated in workshops and institutes or taken courses to increase their knowledge and skills. Their salaries are considerably higher than when they began at a full-time rate of $5,000 a year. They are valued members of the professional staffs in the agencies in which they work.

A three-year follow-up study carried out by Drs. Thomas Magoon, Stuart Golann, and their co-workers from the University of Maryland gave a generally very favorable picture of the counselors as they were seen by employers, supervisors, and co-workers in their places of employment (Golann, Breiter, & Magoon, 1966; Magoon & Golann, 1966).[4]

The second project, as envisioned by Dr. Lourie, had a different task and a different area of specialization. The group of people with whom the trainees were to counsel were to be mothers, and sometimes fathers, of young children, especially preschool children. They were to be primarily from the underprivileged parts of the community. The goal of the work was to be prevention. The settings in which the work was to take place were to be first and foremost the child health clinics of the District of Columbia to which mothers bring their children for routine immunization and general checkups. Other situations in which mothers of young children gather were also to be used, such as nursery schools or day-care centers. These settings are not mental health clinics where people come asking for help with their emotional problems. The job of the counselor in such settings is a different one from that of the therapist in the mental health clinic. The area of specialized knowledge of the counselors in the new project was to be that of child development, and during their training they were called Child Development Counselors.

---

[4] This study will be reported in detail in a monograph which is in the process of publication. Partial reports were made at the Annual Meetings of the American Psychological Association and are abstracted in the following issues of the *American Psychologist:* Vol. 18, 1963, p. 404 (a): "Non-traditionally Trained Counselors–Psychotherapists –Their Training, Employment Progress and Perceived Employability"; Vol. 19, 1964, p. 567 (a): "Evaluation of Mental Health Counselors after Two Years of Employment and Implications for Counseling Psychology"; Vol. 20, 1965, p. 525 (a); "Employment Progress of Non-traditionally Trained Psychotherapists: Three Years of Follow-up Evaluations."

The major difficulty in this program was the definition of just what the counselors were to do. Definition is a difficult matter altogether in the mental health field. In the first project we avoided it as much as possible. But it was possible to demonstrate to the students by example what they were expected to do. They had ample opportunity to find out by observing through one-way screens and by listening to tapes what experienced therapists did. While they learned in this way that no therapist is perfect, they also found some live models which served a useful purpose for as long as they were needed.

In the child health clinics of the District of Columbia no one was doing the kind of counseling we were asking our students to do. Occasionally they were able to observe at Children's Hospital a competent and experienced pediatrician examine a baby, interview the mother, and talk with her about the baby's developmental difficulties. They found this helpful to a degree but, as they were quick to point out, they were not in the position of the pediatrician, who started with an examination of the infant and went on to intersperse medical advice with questions regarding the total family situation. In the child health clinics the pediatricians and nurses were too busy with their large caseloads and their own specific roles to have time to do the kind of counseling we wanted our trainees to learn. This was in fact the reason why the project had been started. There was a need for someone to listen to and offer counsel to the mothers in these clinics, but the traditional personnel had neither the time nor the training to do this. The trainees in the second project not only had to learn a skill which was new to them but had to forge a place for themselves and create a role which was new in the settings in which they worked.

At the same time they had to learn the language of people who came from a background quite different from their own. They were faced with problems which were not the ones with which they were familiar in their own families and in those of their neighbors, namely, the problems of dire poverty and family disruption. Good advice about techniques of feeding, weaning, toilet training, etc. often seemed meaningless when the family was about to be evicted or when none of the various fathers of six children in one family, all under eight years old, was to be found to pay for the groceries.

Another source of frustration which the students met was the lack of understanding of what they were there for which they encountered initially on the part of both patients and some of the clinic personnel. While this was far from true in all cases, it was in some, especially in the beginning, in spite of efforts on the part of the staff to smooth the way for the students.

It was little wonder that the trainees felt discouraged and that the task of training and learning was a difficult one, more difficult than in the first project. Nevertheless all eight women completed the course to the satisfaction of their instructors. Having complained bitterly that they did not know what they were doing, they nevertheless succeeded in creating a valued role for themselves in the settings in which they were placed.

The fact that they and their instructors were middle-class people attempting to work chiefly with patients from a different socioeconomic and cultural background presented difficulties which were not easy to overcome. But in the course of their two years' experience the students did come to be much more comfortable and much more competent in their contacts with patients. In other words, they learned to do something which the students in the first program did not learn. They did not, however, have the practice and acquire the skills and experience in long-term counseling that the students in the first project did.

The two programs went in different directions. The work in the first afforded greater immediate satisfactions. This is one explanation for the fact that the students on the first project put in more hours in practical work than was required of them, so that we considered the program to be the equivalent of a year and a half of graduate work. On the second project we limited the total scheduled time to twenty hours a week in order to demonstrate that in two years half-time, that is, in the equivalent of one year of graduate work, we could train Mental Health Counselors in a particular specialty. This was, we think, demonstrated.

The training, as in the first project, was first and foremost practical. In the second week the students began as observers in the child health clinics, and in the fourth week they were interviewing and taking histories on new mothers. Later on they saw mothers who were either referred by the clinic staff or who were invited by them after some initial contact in the waiting room to continue the discussion in their private offices. The interviews focused on a wide variety of topics. In over one half of them socioeconomic factors, such as lack of housing, clothing, employment, or education, played a major part. Marital or other family discord was a frequent complaint. Problems centering on children included physical complaints such as malnutrition; psychological difficulties, including mental retardation or poor school performance in older children; emotional and social problems such as overdependency, overaggressiveness, fearfulness, and a frequent complaint of "badness." The trainees found that one of their chief functions was that of referral to appropriate agencies for further help. These included psychiatric clinics; but more often they were welfare agencies or clinics for special disabilities, such as speech or hearing. While keeping in mind that their goal was prevention of future mental and emotional disorders in the young preschool children, the trainees found themselves faced with such urgent social and emotional problems in the parents and older children that these often had to be dealt with before either the mother or the counselor could be free to think of the much less pressing problems of the infant or two-year-old, which the mothers often did not even perceive to be present. Some of their instructors emphasized the need for concentration on the area of child development. Others encouraged them to handle whatever problems arose to the extent that they could.

Most of the mothers interviewed in the clinics were seen by the trainees only once. As time went on those students who had been fortunate enough to be assigned for two years to the same clinic began to build up a "caseload" of people who came back to them either in connection with the child's next routine visit or, on special occasions, without the child for the purpose of continuing the counseling interviews. It is clear that from these cases the trainees derived their greatest gratification. And it is from these cases, too, that we have some idea of how much impact the counselors had.

In addition to the practical work in the child health clinics which constituted the backbone of the program, the trainees had other field placements in the second, third, and fourth semesters. These included two semesters for each trainee in a nursery school observing children, counseling with mothers who requested it, and consulting with teachers. Other placements in the fourth semester included maternity clinics, family and child service agencies, and neighborhood centers.

In addition to the practical work, the training included case-seminars and individual supervision. Didactic courses, spread over the two years, covered quite thoroughly the areas of normal child development, physical and psychosocial, with special stress on the early years; general personality development reaching into adulthood and including deviations from the normal; community resource and background studies of the District of Columbia. Briefer courses touched lightly upon many special topics; for example, mental retardation, family dynamics, techniques of school consultation, psychological testing, prenatal care, and frequently encountered medical problems of young children.

It is clear that the students in this program were subjected to many pulls and tugs from both patients and staff. They often protested vigorously. At the end of the two-year training period they demonstrated a remarkably flexible, practical approach to the problems which they encountered. They were not much concerned about what may be considered to be the proper techniques of interviewing. They were very alert to see what works and what does not and to learn from experience. Since they knew that they would be limited to not more than a few sessions with each patient, they acquired a great deal of skill in making meaningful contacts in a single interview. They learned not to waste time, to risk interventions which went to the heart of the patients' worries, and to concentrate on one significant area.

No attempt was made at the end of the training period to evaluate the students as it was done in the first project. There was first of all the practical reason that we were unable to get tape recordings in the clinics so that this avenue of evaluation was closed. Even more important was the awareness on the part of the staff that there is no model by which to judge these students' performance. There is no way to assess adequately the effects they have had upon their patients. It would indeed be asking too much even of an experienced professional to produce results in a brand new situation working only one day a week in each setting. We have, therefore, left the formal evaluation for the next years when the student will actually be employed.[5] We can report, however, that the physicians in charge of the clinics in which the trainees worked during their last semester were unanimous in their appreciation of the services the trainees had rendered. All of them wished that the trainees could continue to be assigned to them as full-fledged counselors. They were also discriminating in their understanding of the variety of individual styles and gifts which the eight trainees demonstrated. Further, the nursery school teachers to whom the students had been assigned earlier in the program agreed that the trainees had all performed competently and usefully in observing children and counseling with mothers.

Seven of the graduates started work part time in March, 1966, as Mental Health Counselors in the Bureau of Mental Health of the Washington, D.C. Health Department. They will work in child health clinics and other centers where they will counsel with mothers and continue to find for themselves the best ways in which they can function. One of the seven accepted a second part-time job as a counselor in a day-care center. Two others continued training part time in agencies which may later find them useful as employees. The eighth was employed as a Mental Health Counselor in the Well Baby Clinic of the Children's Hospital. It seems to us likely that after a few years of clinical experience these women will find themselves teaching, consulting, and administering, as well as counseling.

In arranging for the employment of these trainees the matter of their formal education prior to the project became an acute problem. They were to be employed in the civil service system, which has its own categories. Although the project staff thought that competence as counselors in child development in this group of eight was correlated neither positively nor negatively with years of formal schooling, the requirements of the system made hiring of those with bachelor's degrees much simpler than of those without. Along with the question of whether they could be hired at all came the question of whether they could be hired at the same grade. The emotional stress which this caused in the group can be imagined but is not in itself important. They all survived the strain. The decision was that they could all have the same salary (approximately $5,000 per year full time) and the same grade (5), but those with degrees would be classified in the professional series; those without, would not. They are, however, all expected to do the same kind of job. It is no doubt impossible to create any system on a large scale, like the civil service, which will be just to all individuals.

---

[5] This evaluation will be carried on by Stuart Golann, Ph.D., of the University of Maryland and his co-workers.

The experiment demonstrated that a college degree is not a necessary prerequisite for training as a Mental Health Counselor. The trainees who had only one or two years of college were as active and full participants as those with some graduate work. From the point of view of function, graduation from college is an irrelevant fact; from the point of view of fitting into the existing system, the discrepancies in formal schooling created considerable difficulty.

The official classification of at least five of the eight trainees as professionals in the civil service system has been a source of satisfaction to the staff of both projects, who have consistently maintained that their students were being trained not as technicians or subprofessionals, but as professionals. By this we meant that in both programs the students were exposed to a variety of theories and practices with the purpose of helping them ultimately to find their own way. They were not expected to follow directions according to a set method. They were to adhere to high standards of ethics and of independence of thought. There need be no fear that these trainees will uncritically and gullibly go along with unsound theories or untried practices. Typical of all of them is the comment of one who, having attended a large professional meeting, noted that mutually contradictory claims for various therapeutic techniques were being made with equal dogmatism, one just down the hall from the other. She wondered how people could be in a field for so many years without realizing the unsoundness of such oversimplified statements.

The programs just described have often been referred to as training of lay persons, or of volunteers, or of subprofessionals or nonprofessionals. If they have contributed to an interest in the greater use and development of people in these categories, it is a source of satisfaction to their authors. But the programs themselves have not been devoted to this task. They have addressed themselves to the shortages at and near the top. While we experiment with the use of the indigenous worker, the teacher's aide, and the technicians of various kinds, we should not forget that there is an equally great need to add to our supply of trained "first-rate hearts and minds to guide our ever more complex society" (Michael, 1965, p. 284). We have learned at last by turning our attention to the underprivileged that when there is little or no opportunity, there will be little or no ambition, that when there is no outlet for the use of skills, the skills will not be developed. The same is true for the mature woman with her largely unused capacity for intellectual and emotional growth. The really deeply gratifying aspect of the work on both programs was the facilitation of significant development in the students.

The projects have demonstrated that important jobs at a professional level can be filled by superior people with less formal training than is usually required. They have also suggested that modifications of some aspects of present professional training may be desirable. Mature women represent a great unexploited resource that is available for high level, nontraditional training. But there are also factors operating against their use. Many guardians of our present system fear that shorter, nontraditional training of people who lack the usual formal prerequisites to do jobs which now require long, traditional professional training will be an opening wedge leading to the destruction of the high standards for which they have fought. This is an understandable fear. Nontraditional training programs which claim, as ours have claimed, to prepare people to work as professionals at a high level must prove their worth and must provide their own safeguards against misuse. If this is done, and it can be done, then such programs offer a way to alleviate the manpower shortage near the top in the mental health field while providing an avenue of growth and development to mature women seeking second careers.

REFERENCES

Golann, S., Breiter, D., & Magoon, T. M. A filmed interview applied to the evaluation of mental health counselors. *Psychotherapy,* 1966, *3,* 21-24.

Magoon, T. M., & Golan, S. E. Nontraditionally trained women as mental health counselors/psychotherapists. *Personnel and Guidance J.,* 1966, *44,* 788-793.

Michael, D. Urban policy in the rationalized society, *J. Amer. Inst. Planners,* 1965, *31,* 283-288.

Rioch, M. J., Elkes, C., & Flint, A. A. *National institute of mental health pilot project in training mental health counselors.* Washington, D.C.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1254, 1965.

8

NEW MANPOWER FOR MENTAL HOSPITAL SERVICE[1]

Richard Sanders

Philadelphia State Hospital

INTRODUCTION

There is a continuing and growing shortage of professional manpower for mental health services. Public acceptance of mental health services has increased to the point where a larger proportion of the population is now seeking help. The Manhattan Study (Srole, Langner, Michael, Opler, & Rennie, 1962) indicates that an even greater proportion is in need of help. The shortage of professional mental health personnel becomes critical when considered in terms of the rapid rate of population growth and the anticipated population explosion. Indeed, even now the manpower shortage is so great as to result in gross deficiencies in mental health services.

George Albee (1959) in his study of *Mental Health Manpower Trends* relates the shortage in mental health manpower to the shortages in professional manpower in general. He contends that our system of secondary and higher education fails to stimulate sufficient numbers of bright young people to seek professional careers. He attributes this to anti-intellectual, anti-educational, and antiprofessional social and cultural values. Our society rewards private initiative and individual enterprise. The makers and sellers of goods reap greater financial rewards than those who offer a professional service. Not only are the rewards greater for the entrepreneur but his investment of time in education is considerably less, and he reaches high-level earnings much sooner.

What then are the inducements to enter the professions? When one considers that it takes twelve years of post-high school training to become a psychiatrist, ten or more years to become a psychologist, and seven years to become a social worker, it is understandable that so few are sufficiently motivated to enter these mental health professions. Furthermore, in view of the increasing competition between private and public organizations for the already short supply of mental health personnel, it seems that there will never be enough manpower for public service.

---

[1] The author is indebted to Bernard Weinman, Ph.D., for his critical review of the contents of this chapter and his help in preparation of the manuscript.

The state hospital, the "stepchild" of the mental health field, cannot help but be affected by the scarcity of professional personnel. Low salaries and poor public image hardly help the state hospitals to compete for professional personnel. So long as custodialism was the prevailing ethos in the mental hospital, the need for professional personnel could be minimized. Traditionally in state hospitals, professional personnel fulfilled "gatekeeper" functions such as admissions, transfers, and discharges, while the nonprofessionals, the attendants, carried out the bulk of the custodial functions. Following World War II, with the advent of the somatic, chemical, and psychological therapies and recognition of a more favorable prognosis for the mentally ill, a demand was created for more humanistic and therapeutic regimens for patients. The state hospital, in the face of an already short supply of professional personnel, was ill prepared to share in this new *Zeitgeist* of more humanistic, rehabilitative services.

In an effort to meet the public clamor for more humanistic treatment, the state hospital attempted to mobilize the therapeutic potential of its least costly and most available employee—the attendant. The attendant, however, is already so heavily burdened wih custodial functions that he has limited time available for therapeutic services. Furthermore, the rewards for psychiatric aide work are usually so poor that those choosing this type of employment have been reported to be only marginally employable and poorly educated. This type of background limits the degree to which these people can assimilate and apply specialized training. Although considerable effort is being invested in upgrading the training of the attendant to effect a greater therapeutic impact on the patient, this caliber personnel offers limited hope of adequately fulfilling the therapeutic needs of the state mental hospital.

Quite obviously, if the large institutionalized patient population is to be adequately treated, manpower must be drawn from sources other than existing hospital personnel. These new personnel should not be expected to function in the established, highly specialized roles of the existing mental health professions, but rather in new roles that will maximize the therapeutic potential of the hospital. These roles, then, must encompass a treatment function and must be designed to serve the large numbers of patients currently untreated and languishing in hospital wards.

SOCIOENVIRONMENTAL THERAPY

A treatment approach which has been found to be both promising and appropriate for the large state hospital population is socioenvironmental therapy. Unlike traditional hospital care, which tends to stabilize patients in custodial routines, socioenvironmental therapy is designed to activate social behavior through democratic, humanistic treatment and interpersonal activities.

Socioenvironmental therapy has its antecedents in the "total push" treatment introduced by Myerson (1939), the "therapeutic social club" and "situational therapy" of Bierer (1942, 1951, 1959), the "therapeutic community" as conceived by Jones (1953), the principles of group treatment advanced by Bion (1961), and the application of these principles to comprehensive hospital programs for psychotics by Greenblatt, York, and Brown (1955). Meyerson stressed activation through forced participation in activities. Bierer attempted to restore the patient to social responsibility and competence through self-governing social groups and involvement in controlled social situations. Jones, working with sociopaths, extended the concept of the therapeutic social club to total community life. He emphasized democratic living, self-government, and confrontation with reality. Bion utilized group interaction and group forces as the therapeutic agents to effect productive behavior. Greenblatt demonstrated the therapeutic value of reorganizing the mental hospital and its wards in accord with social treatment principles. Socioenvironmental therapy, today, consists of an extension of composites of these ideas applied to ward programs, day hospitals, open hospitals, and aftercare centers. In general, the reports on the effectiveness of such newly developed programs have been favorable.

SOCIOENVIRONMENTAL TREATMENT OF CHRONIC MENTAL PATIENTS

For the past seven years the Psychology Department of the Philadelphia State Hospital has been concerned with the development of socioenvironmental programs for chronic patients and with the evaluation of the therapeutic effectiveness of different forms of this treatment. In view of the characteristic isolation and withdrawal of chronic psychotics, social interaction was considered the major treatment variable. The social treatment programs designed to induce, augment, and manipulate appropriate social behavior included three major components, namely, a social milieu, rehabilitation skills and content, and a corrective experience.

The social milieu, or therapeutic community, was established by modifying the physical environment of the state hospital to approximate that of the extramural community, changing staff attitudes to attain a more optimistic view of the chronic patients' potential for recovery, encouraging free communication among patients and between patients and staff, introducing patient social organizations to permit the emergence of spontaneous social behavior, and establishing patient government to permit patients to be more instrumental in determining and managing their daily lives.

The physical environment of the state hospital was changed to approximate more closely the extramural community. Patients were moved from large dormitory-type buildings to smaller buildings with private rooms. Males were housed in three small cottages, each cottage containing twenty-four private rooms. One of these private rooms served as a den or game room. A large, comfortable living room in each cottage was furnished with a television set and reading materials. Every patient was issued a key to his room and had complete responsibility for the daily care of his room. Females were housed in a larger, three-story building, the ground floor of which was devoted to office space for project personnel. The sleeping rooms on the second and third floors varied in size so that some patients had private rooms, while others slept two to a room. The maximum bed capacity was thirty-six. There was a lounge on the second floor, and another on the ground floor. Both were shared by all patients residing in the building. In most respects the accommodations were similar to those for the males. All patients were served meals "family style" in a dining hall operated and maintained partially by the patients.

A second modification of the state hospital was the promulgation of both staff and patient attitudes conducive to the establishment of a therapeutic community. Staff meetings were held regularly with the nursing personnel immediately involved in patient care. These meetings were designed to foster the attitude that chronic mental patients could be rehabilitated through social interaction. At these meetings, staff members were oriented to assist patients in assuming responsibility for their social community. Among patients, the feeling of responsibility for their social community was generated through individual conferences and regularly held group meetings conducted by staff members. In this manner, a major prerequisite of a therapeutic community—free communication among patients and between patients and staff—was attained.

A third factor in the development of the therapeutic social living situation was the initiation of a variety of social organizations. The purpose of these organizations was to provide nondidactic social groups within which spontaneous social behavior could emerge. Accordingly, attendance was voluntary and participation informal. Monthly parties and regularly held meetings of social clubs, such as a Model Railroad Club and a Personal Grooming Club, were available to all patients. An additional organization, the Alumni Club, was open both to patients who were preparing to leave the hospital and those who had already been discharged. This club offered a familiar and supportive group for patients during their initial period of adjustment to the extramural community and afforded encouragement for patients almost ready to leave the hospital.

A fourth innovation in developing the therapeutic community was the establishment of patient government to augment the resocialization process by granting the patients the responsibility for cottage management, and by establishing the modes of interaction for meeting this responsibility. Patients elected executive officers and a council. The executive officers conducted meetings, at which patients could bring up problems for discussion and action. Patients took responsibility for the conduct of the more routine aspects of cottage management such as the organization of housekeeping details, scheduling of wake-up teams, and regulation and scheduling of the use of cottage facilities such as showers and television. Elections were held at sufficiently frequent intervals so that almost all patients were able to become involved in leadership functions.

Rehabilitation skills and content were provided in a structured group activity program, consisting of group tasks varying from simple recreational pursuits to complex, community-centered activities. Training in the repertoire of social behaviors necessary for everyday living was available in a special set of group activities. Through discussions, practice, and trips to the community, patients were instructed in personal grooming, preparation of meals, repair of clothing, budgeting, use of transportation and communication facilities, and other community resources. In addition, these activities also provided training in the basic requirements of interpersonal relations, the essentials of etiquette, meeting and interacting with people in new situations, and means of dealing with interpersonal stress.

A corrective experience was provided throughout the program in individual counseling sessions, group activities, and daily life experiences. The emphasis was on providing pressure toward increased interaction, reinforcing socially adaptive behavior, discouraging and modifying maladaptive behavior, and helping patients to develop more appropriate ways of coming to grips with the problems of everyday living. To accomplish these goals, techniques which focus on the behavior of the individual and/or the group processes were utilized.

The results of the study of the therapeutic efficacy of these programs (Sanders, Weinman, Smith, Smith, Kenny, & Fitzgerald, 1962; Sanders, Smith, & Weinman, 1967) indicate that socioenvironmental treatment does, indeed, improve the social functioning of most chronic patients and has particular utility for the older, more chronic patients who show more favorable psychiatric adjustment and heightened release rates as a consequence of this treatment.

NEW PERSONNEL

The question arises as to which type of personnel should be trained to utilize the techniques of social interaction therapy. In the Philadelphia State Hospital Project,[2] personnel from all hospital disciplines were trained to conduct social interaction therapy. Five years of experience in the training and evaluation of these personnel has made it clear that none of the existing disciplines is fully equipped to practice social interaction treatment without additional training. It is also apparent that a fairly broad educational background is one prerequisite for successful learning and application of the concepts of social interaction therapy.

---

[2] The programs to be described have been supported by two NIMH grants: OM-126 Rehabilitation of the Chronic NP Patient: A Pilot Study (1958-1965); MH-8210 Training New Workers for Social Interaction Therapy (1963-1968).

Social interaction therapy has several requirements: an understanding of abnormal behavior, proficiency in the use of activity skills and group tasks to stimulate interaction, knowledge of the educational content necessary to reorient the institutionalized patient toward extramural living, familiarity with the therapeutic aspects of a social milieu, and finally, the ability to utilize group and individual techniques to modify maladaptive behavior and provide more adaptive ways of dealing with interpersonal situations.

Personnel having the background for becoming good social therapists might be drawn from the already depleted disciplines of psychiatry, psychology, social work, occupational therapy, and nursing, but their recruitment for supplementary training in social interaction therapy would serve to deprive patients of sorely needed specialized professional services. The most numerous personnel available are the attendants and the activity aides. Although some of these are uniquely suited to become social therapists, the majority is not of a caliber appropriate for such training and service.

In view of the apparent necessity for a fairly broad educational background as a prerequisite for training in socioenvironmental therapy, the college graduate seems to be the most suitable candidate for this training. Hopefully, he can be trained in a relatively short time period to provide the generalized therapeutic services which constitute socioenvironmental therapy.

The Commonwealth of Pennsylvania has long felt the need for new therapeutic services and new personnel to provide such services. The use of college graduates as mental health workers in state institutions was first explored in a Technical Assistance Conference in March, 1962. In June, 1962, the Director, Bureau of Mental Hospitals, Department of Public Welfare, approved the proposed Philadelphia State Hospital plan for recruiting and training college graduates for socioenvironmental treatment. In July, 1963, the National Institute of Mental Health awarded the Psychology Department of the Philadelphia State Hospital a grant to train approximately thirty mental health workers in socioenvironmental treatment techniques. The training program was under way in January, 1964, after a training staff had been selected, the course content had been determined, and the six most qualified applicants had been appointed.

THE TRAINING PROGRAM

The following are the goals of the training program: to orient college graduates, novices in the mental health field, to mental illness and mental hospitals; to instill in them humanitarian attitudes toward mental illness; to train them in the special skills necessary for social interaction therapy; and finally, to prepare them to deal effectively with other mental health disciplines in establishing programs of social interaction treatment on hospital wards.

The training program designed to facilitate the attainment of these goals now includes five courses: Personality Theory, Psychopathology, and Treatment; Group Dynamics; Social Institutions; Activity Skills; and Social Interaction Therapy.

The course in Personality Theory, Psychopathology, and Treatment is divided into three phrases. The first phase reviews the developmental sequence and focuses on the type of object relations prevalent during each critical period, as well as on the dynamics of interpersonal behavior. The second part focuses on psychopathology and reviews recent research findings regarding the biological, biochemical, physiological, psychological, and social bases for personality malfunction. In the third phase, current treatment procedures including somatic, chemical, psychological, and socioenvironmental are discussed and evaluated.

The course in Group Dynamics consists of two parts: participation in an ongoing self-evaluation group, and a didactic course in the theory and conceptions of group life. The first-hand experience of being part of a group that studies itself aids the development of the participant's sensitivity to his own feelings and to the feelings of the other members of the group. The study group utilizes the group situation as a teaching device and deals with anxiety-arousing areas of group life. The historical antecedents of the student's own adjustments and defenses are not investigated. The student focuses on the group's defenses against anxiety and on his own contribution to the group process. In this manner the student gains insight into the techniques through which individual and group behavior are modified by group processes. The didactic course which follows the study group is then utilized to provide a theoretical framework for the study group experience and a broader range of approaches to the use of groups in the modification of behavior.

The course in Social Institutions is designed to give the trainee first-hand experience with the therapeutic programs of the hospital. This includes an orientation to each of the hospital service disciplines and experience one day per week during the first six months of training in assisting the various disciplines in conducting their specialized therapeutic services. Following this practical experience the student is presented didactic material concerning the impact on the mental patient of social institutions such as the family, the community, the ward, and the hospital.

The Activity Skills course is designed to teach the trainees the general skills necessary to help patients develop and execute group projects. The content of this course includes arts and crafts, recreation, sewing, cooking, and budgeting. The course presents the mental health worker with a general background of activity skills which can then be utilized as vehicles for stimulating group interaction and effecting appropriate group behavior. Trainees also learn how the more specialized skills of occupational, recreational, and music therapy can be used to enrich the hospital therapeutic program. Instead of providing only didactic training in the arts and crafts, the classes are conducted using group techniques similar to those which the mental health worker will utilize in conducting patient activity groups. This teaching procedure gives immediate application to the skills learned.

The course on Social Interaction Therapy is fundamental in preparing trainees to conduct social treatment with groups of chronic patients. This course provides practice in using group process to improve interpersonal behavior and to correct maladaptive responses, in teaching mental patients how to live in the extramural community, and in structuring a ward environment into a social milieu. As a first step in this course, trainees under supervision conduct activities in an established program at the Rehabilitation Center. As group leaders for these activities, they are guided by the level of social behavior manifested by patients and provide the patients the support, encouragement, and assistance needed to progress from rudimentary interpersonal responses to the social complexities of group participation. Through group leadership, trainees learn to utilize the group for setting goals, for making decisions, and for helping to solve interpersonal problems between group members, and thereby correct maladaptive behavior and enhance social adjustment of group members.

Following supervised experience in the conduct of activities in the ongoing program, trainees move to a back ward where few if any programs are available. Here the task consists of selecting an appropriate sample of patients, structuring a therapeutic milieu, establishing a program of activities especially suited for the population selected, implementing and conducting the program activities, and integrating the members of other hospital services into this program. To date, this type of experience has led to the establishment of two levels of programs on the back wards: a patient government program for higher level patients, and an activity program for more regressed patients.

The patient government program utilizes both discussion and performance activities to stimulate interaction and prepare the patients for extramural living. Here the group leader's task is to get the patients to assume leadership roles in the activities and to moderate the pressure which the group exerts on individual members to participate in the group processes. The regressed-patient program relies more on performance-type activities to activate patients and involve them in social relations. This program requires that the group leader assume a more directive and controlling role in order to initiate even rudimentary group interaction and prepare the patient for higher order social relations. The patient government programs as well as the programs for regressed patients have involved, in therapeutic activities, many patients formerly neglected because of staff shortages.

Supervision in the conduct of social interaction treatment is the key teaching method utilized to develop group leader skills. These skills are inculcated primarily through a supervisor's critical appraisal of actual performance and the trainee's continued practice to perfect the application of approved techniques. Supervision focuses on offering the trainee the opportunity to integrate the content presented in the various courses and to apply it in accordance with his understanding of the needs of the group and its individual members. The supervisory process is directed toward a depth examination of the trainee's involvement, his awareness of group processes, the appropriateness of his leadership behavior, as well as an exploration of alternative approaches to group problems. The goal of supervision is the emotional and intellectual involvement of the trainee in the learning process.

Supervision is based upon actual observation of the trainee's behavior as a group leader. Extensive use is made of the two-way mirror room for direct observation and taped recordings for review of experiences. Supervision is provided on both an individual and group basis. Each trainee is assigned a staff supervisor who observes one trainee-conducted group session per week. In addition, trainees observe each other conducting groups on alternate weeks. Supervisory sessions follow these observation sessions.

The training program is a one-year program; six trainees are accepted every six months. Approximately one-third of the time is spent in didactic course work and two-thirds in supervised practice in conducting social interaction therapy groups.

A major problem in establishing such a training program is the recruitment of a competent training faculty. A core of experienced staff who had been involved in the original socioenvironmental programs was available to serve as model group leaders and participate in the didactic and supervisory aspects of the program. Finding additional staff trained and experienced in group work with chronic mental patients was a difficult task. However, the services of a psychiatric social worker, a doctoral candidate who had had considerable experience in working with groups of chronic mental patients, were obtained. Also secured, on a part-time basis, were the services of several psychologists with considerable group psychotherapy experience with mental patients. Thus, the training faculty is multi-disciplinary, composed of psychologists, group social workers, and occupational therapists. Staff psychiatrists are also utilized for special lectures on diagnostic classification, psychopathology, and psychotherapy.

The recruitment of college graduates for training as mental health workers has been surprisingly successful. The $3600 annual NIMH stipend offered from grant funds and the opportunity for training for employment in the mental health field at an annual salary of $6090-$7775 seem to be sufficient inducements to attract a large number of applicants.

A group screening procedure had to be developed to make the selection process efficient and economically feasible. The screening teams, composed of a psychologist and a group worker from the training faculty, developed a number of situations which would elicit sufficient applicant participation to enable staff to rate the applicants on a variety of personality traits. For example, in one screening situation, applicants are paired and given five minutes in which to learn about their partners prior to introducing them to the larger group. Another screening procedure requires the candidate, after hearing a case study of an individual under stress, to devise a plan of action which he feels will be helpful to the disturbed individual. A third screening task requires the candidate to present a self-analysis. These tasks generally produce an array of behavior useful for rating such traits as altruism, personal warmth, independence, drive level, emotional expression, flexibility, and interpersonal skills. Candidates with the best ratings are selected for admission to the training program.

EVALUATION OF THE PROGRAM

A number of major research issues must be resolved before the success of the training program can be determined and a broader application of the services of this new worker can be made. The first question is whether or not the college graduate mental health trainee is able to master the skills of social interaction therapy. To answer this question, two types of evaluations are made. The first is a subjective appraisal by the training staff of the trainee's performance in the program: how well he learns and applies the course content; how he gets along with patients, staff, and fellow trainees; how dependable and reliable he is; how much initiative and perseverance he shows. Since every trainee is assigned quarterly to a different staff member for supervision, the supervisor's ratings serve as systematic measures of the trainee's progress.

A more objective assessment derives from direct behavioral observations of the trainee's group leadership performance by trained raters who use the Group Leader Evaluation Inventory (GLEI)—a locally constructed instrument—to record their observations. This instrument, basically, is a checklist composed of items judged by the training staff to be representative of sound group leadership or to be representative of behavior which obstructs or defeats the aims of social interaction therapy. Items such as "maintained group process when faced with disruptive behavior" or "related seemingly irrelevant or meaningless remarks to the main topic of discussion" are viewed as positive leadership behavior. Items such as "belittled contribution of individual patients" or "ignored, suppressed, or otherwise disowned pathological behavior" are examples of negative leadership behavior. Weights are assigned to each item in accord with empirically determined frequencies of occurrence in group situations and the mean ratings given to each item by personnel experienced in the conduct of social interaction treatment. A total of sixty-two positive and negative items are included in the checklist. Also included in the GLEI are three rating scales which are designed to measure: (1) how often the group leader tries to get patients to interact, (2) the level of therapeutic interaction displayed, and (3) the number of patients who actively participate in the group process. At regular intervals, trained staff observe the group leadership behavior manifested by the trainess and complete the GLEI. The inter-rater reliability on the GLEI has been found to be quite satisfactory.

An additional criterion measure of success derives from the sociometric rankings of trainees by supervisors and peers. At completion of training, trainees are ranked in regard to cooperativeness, relationship with peers, relationship with authorities, efficiency as group leader, etc. The individuals performing the sociometrics are asked to rank three fictitious trainees: Mr. Above Average, Mr. Average, and Mr. Below Average. These fictitious persons serve as "rating anchors," allowing comparison of trainees across groups.

A second research task is the identification of the characteristics of a successful mental health worker. Success in this area would be of considerable help in the selection of candidates for training. During the first week of the training program, trainees are given a number of personality tests (California Psychological Inventory, Interpersonal Check List), interest inventories (Allport Vernon Study of Values, Vocational Preference Inventory), attitude scales (Opinions about Mental Illness), and locally standardized group tasks. Scores on these measures will be examined after all trainees have completed the training program in an effort to discover those personality factors which predict the performance criteria. Some of these measures are repeated at the end of the training program, so that changes in attitudes and/or awareness of self and others, which occur as a result of exposure to the training program, can also be identified and related to the performance criteria. The prediction problem is a complex feature of this research. This problem is further complicated by the fact that only a small number of mental health workers are being trained and that the group selected for training is markedly homogeneous. Both factors reduce the chances of finding significant correlations between personality measures and performance criteria.

From a hospital service point of view, the training program is already paying dividends. Fifteen out of the first twenty-four trainees are now employed at the hospital to provide therapeutic services on wards heretofore exclusively directed toward custodial care. Of the nine remaining trainees, four are employed at a neighboring state hospital, one is employed by a private agency providing services to chronic mental patients in the community, and two returned to graduate school following completion of our program. Only two trainees dropped out for personal reasons before completion of training.

CAREER OPPORTUNITIES FOR THE NEW PERSONNEL

The issue of what career opportunities the Commonwealth will make available to the graduates of the Mental Health Workers Training Program is still being resolved. At first, the establishment of a new and separate profession, the Mental Health Worker, was considered. The problems of establishing such a new profession are numerous and seem insurmountable. The resistance of the established mental health professionals would have to be overcome, and a new and graduated scale of duties and responsibilities would have to be established within the state system to permit the mental health worker's professional advancement and commensurate remuneration. Also, in order to traditionalize this new profession, a university would probably have to take over part of the training program to give academic recognition and to augment the current program with additional courses to lead to an appropriate professional degree. If a new profession were established, its members would be expected to apply social treatment principles more broadly, not only in mental hospitals for chronic patients but also in schools for the retarded, child development centers, and mental health centers. Obviously, the state hospital by itself cannot be expected to provide the breadth of training required to prepare workers for general social treatment services in mental health facilities. A more comprehensive training program would have to be developed through the cooperation of the university and other mental health facilities, each facility offering training specialized for its own service needs.

A second avenue for establishing career opportunities for mental health workers is to incorporate them into existing hospital disciplines and hierarchies. For example, employing mental health workers in the Activity Therapies Department was considered at first. Here, too, considerable resistance was encountered. The resistance took the form of "Sure we'd like to have these trained personnel as members of our staff, but in order to make them comparable with existing staff, wouldn't you first have to give our current personnel the same kind of training?" The fear was that the new mental health workers might dominate the activity workers and gradually subjugate them. Actually, had the Activity Therapies Department accepted the mental health workers, the opposite might have occurred, namely, the activity therapists might have assimilated and subjugated the mental health workers and used them for hospital-wide mass activity programs, rather than for small group treatment programs on segments of hospital wards.

A third course of action, and the one which offers the greatest promise of immediate success, is to establish career opportunities for these new workers as a subprofessional group in the psychology hierarchy. Since psychology undertook the task of developing the techniques of social interaction therapy and established the training program to prepare college graduates to utilize these techniques, the resistance from psychologists to this new group of workers tends to be minimized. Furthermore, a professional ladder for psychologists already exists. The Commonwealth of Pennsylvania is making available Government Career Trainee positions for the employment and training of college graduates. These government career positions can be used to train college graduates for psychological service. Eventually, Commonwealth funds will replace the NIMH stipends which currently support the mental health worker trainees during the one-year training program. Upon completion of the training program, the new workers will be eligible for appointment as Psychological Service Associate 1's, the entrance position in the Psychology Series in the Commonwealth of Pennsylvania. The graduates of the Mental Health Worker Training Program, therefore, will have ready access to a career in psychology. By obtaining a master's degree in one of the specialties of psychology these workers will be able to move up the professional ladder to higher levels of responsibility and commensurately higher salaries.

In order to traditionalize the Mental Health Worker Training Program and establish this group as a subprofession of psychology, discussions are currently under way with two of the neighboring universities regarding the possibility of accreditation for the training program. A training syllabus has been prepared for evaluation by the curriculum committees of these universities. Since the content of the didactic courses offered in the training program is comparable to the content of established university courses, equivalent graduate credits might be offered for the courses in our training program. Trainees would therefore be working toward their graduate degrees while engaged in training at the hospital. Those who wish to advance in the psychology hierarchy could complete their master's degrees at the university. An added inducement which makes such graduate training even more attractive is the Commonwealth's Tuition Reimbursement Program, which would pay the tuition costs of such further academic training.

PROBLEMS IN TRAINING NEW MENTAL HEALTH PERSONNEL

The training of new workers for subprofessional service in the mental health field should not be undertaken without an awareness of the problems posed by such an endeavor. A major disadvantage of training for specific job functions is the limited job flexibility and the danger of rapid job obsolescence. The professional psychologist, by virtue of having experienced a broad, theoretically-based training program, is prepared to offer a fairly wide range of services. Also, the conceptual foundation of his training prepares him to integrate and apply the new developments which emerge in his field. The one-year Mental Health Worker Training Program is necessarily oriented to specific aspects of treatment. Accordingly, this training program restricts the presentation of concepts to those necessary for the learning and application of social interaction treatment techniques. The mental health worker is prepared almost exclusively for this delimited job function, and he is not fully prepared to integrate or apply new and emergent techniques on his own. It therefore behooves the trainers and supervisors of such personnel to establish continuous in-service opportunities designed to upgrade their training, maintain their interest, and help them keep abreast of new developments. Industry utilizes this practice to upgrade personnel and facilitate manpower shifts when job functions become obsolete. The mental health field must be prepared to follow and surpass the example of industry in establishing such in-service programs.

Quite conceivably, socioenvironmental treatment, which looks so promising today, will be replaced by more successful techniques in the near future. The research at this hospital is based on work with the top 15%-30% of the chronic population, namely those patients showing at least rudimentary social responsiveness. Favorable results and the urgent need for such specialized services impelled the initiation of the current training effort before more broadly based evidence of the utility of the techniques was available. This is similar to the general practice prevalent in the mental health field. New techniques are applied as soon as there is evidence that they result in a more favorable outcome than do traditional techniques.

A second problem area is the resistance of the established mental health disciplines to new workers and new techniques. Each discipline tends to guard jealously its rights and prerogatives and look with suspicion at the newcomer. Since the mental health worker, in developing social interaction activities, deals with some of the content and problem areas which are in the purview of the traditional disciplines, these disciplines tend to view him as duplicating their services. The mental health worker thus can become a focal point for much defensive hostility. His efforts are frequently greeted with the protest, "We've been doing this all along." There is little doubt that the mental health worker invites such resistance at times. Slavson once indicated that the only way he could obtain acceptance of group therapy by the medical profession was to emphasize the limits of this system of therapy. However, some of our mental health workers are unable to effect such modesty. Too often, they adopt the posture of a Pinel loosening the chains of the patients. This attitude is bound to arouse the ire of personnel, many of whom are dedicated to patient service. To be sure, the youth and enthusiasm of the mental health workers are natural attributes for the learning and successful application of new techniques. However, their enthusiasm can be manifested with such zeal as to sweep aside the contribution of others and thus potentiate the resistance of the very personnel with whom they must work in close collaboration.

A third problem area which needs to be anticipated in the training of new personnel for mental health service is the possibility that these more limited, specifically trained personnel will present themselves to the public as fully trained professionals. This danger is at a peak when the supply of existing professionals is limited and the demand for their services is great. Two types of safeguards can be employed. The first needs to be built into the training program itself. In the current program, trainees are exposed to a code of ethical practices and indoctrinated with the attitude that they are prepared to work collaboratively with other professionals, but not independently from more broadly trained individuals. A second safeguard, external to the training program, is derived from the current effort to establish standards and certify or license those practitioners qualified to offer services to the public. The mental health workers clearly are not qualified for such independent service.

The dangers inherent in the training of subprofessional workers do not outweigh the advantages derived from the services which they can provide. The established mental health professions are presently looking within their areas of functions and services for generalized and routinized duties which can be fulfilled by relatively untrained personnel. Each of the professions is already using or recruiting and training its own subprofessional workers. Psychiatry is using the medical student for some general medical services in the mental hospital. Social work is recruiting bachelor's level personnel untrained in social work practices for on-the-job training for general casework services. Psychology is training master's and bachelor's level personnel for psychometric services in the mental hospital. However, each of these disciplines still must do its own research and development work to uncover new types of specialized services which would maximally utilize new personnel to improve the overall hospital treatment program.

The uncovering of such new hospital services to augment and improve existing hospital treatment programs can best be undertaken by hospital-based personnel, since they are most aware of the hospital's needs. Needless to say, most state hospitals do not have the caliber personnel to undertake such a research and development task. However, each state system has within it personnel with sufficient intelligence, dedication, and sheer naïveté to enable them to tackle this task. The institutes which various states have established to serve as centers for training and research have failed to fulfill this research and development task. These institutes have become the domain of the neighboring medical schools and are used for the training of psychiatric residents. The research problems undertaken at these institutes are either of a traditional nature, in accord with the traditional training at these institutes, or of a basic nature, in accord with the academic interests of the faculty. Program research, so necessary for the development of new techniques for the treatment of large numbers of patients languishing on state hospital wards, is rarely undertaken by these institutes. This task has fallen to the staff of the service institutions, namely people like Jones in England, Sivadon in France, Fairweather, the Philadelphia State Hospital group, and others in this country. The service institutions, having taken the initiative for developing new treatment procedures, will also have to pioneer in the training of new personnel to implement these procedures on a broad scale and thus help fill the vast demand for therapeutic services.

REFERENCES

Albee, G. W. *Mental health manpower trends.* New York: Basic Books, 1959.

Bierer, J. Group psychotherapy. *Brit. Med. J.*, 1942, *1,* 214-217.

Bierer, J. *The day hospital, an experiment in social psychiatry and synthoanalytic psychotherapy.* London: Lewis, 1951.

Bierer, J. The theory and practice of the day hospital. *Lancet,* 1959, 2, 901-902.

Bion, W. R. *Experiences in groups.* New York: Basic Books, 1961.

Greenblatt, M., York, R. H., & Brown, E. L. *From custodial to therapeutic patient care in mental hospitals.* New York: Russell Sage Foundation, 1955.

Jones, M. *The therapeutic community.* New York: Basic Books, 1953.

Myerson, A. Theory and principles of total push in the treatment of chronic schizophrenia. *Amer. J. Psychiat.*, 1939, *95,* 1197-1204.

Sanders, R., Smith, R., & Weinman, B. *Chronic psychoses and recovery: an experiment in socio-environmental therapy.* San Francisco: Jossey-Bass, 1967.

Sanders, R., Weinman, B., Smith, R., Smith, A., Kenny, J., & Fitzgerald, B. Social treatment of the male chronic mental patient. *J. nerv. ment. Dis.*, 1962, *134,* 244-255.

Srole, L., Langner, T. S., Michael, S. T., Opler, M. K., & Rennie, T. A. C. *Mental health in the metropolis: The midtown Manhattan study.* Vol. 1. New York: McGraw-Hill, 1962.

9

THE TRAINING OF HUMAN SERVICE AIDES[1]

William L. Klein

Howard University

In the spring of 1964, ten young people, all between the ages of seventeen and twenty-one, began a three-month training program[2] to prepare them for jobs as aides and assistants in child care centers, neighborhood recreation programs, and social research projects. The seven boys and three girls who had been selected were all high school dropouts. Four of the boys had delinquent records, while two of the girls had given birth to children out of wedlock some time before the program began. All were Negro youth from the poor "central city" area of Washington, D.C., chosen from a pool of individuals referred to the program by several youth-serving agencies in the city. No attempt was made to pick out the best of the applicants. Instead, on the basis of demographic data and individual interviews, each person who applied was assigned a "risk category" rating—essentially, a prediction derived from previous employment and delinquent history, school achievement, and personal and social behavior as to how likely it was that the individual would complete the training and function effectively on the job. Applicants were paired on the foregoing variables, as well as on those of age and sex. One member of each pair was then randomly chosen for the training group; those not selected constituted a control group. In this way, the training of the aides, to be described in this chapter, began.

Six months later, after the training was completed and the aides were all working in city recreation programs, child care centers, and social research projects, none had dropped out of the program; and there were no clear-cut differences in job performance between those originally described as poor risks and those considered good risks. With one exception (an arrest for disorderly conduct) they had no further involvement with law enforcement agencies. In most cases their supervisors found them valuable additions to program staff—eager to learn, quick to catch on, and often innovative and resourceful in carrying out their assignments. One of the aides, working in a local demonstration program aimed at army enlistment rejectees, was quickly "promoted" to fill a slot vacated by the dropping of a graduate student who had been found wanting. Two others played a major role in organizing neighborhood youngsters into activity groups that were to form the basis of an experimental community mental health program.

---

[1] This chapter is derived from various publications and reports of the Institute for Youth Studies, Howard University, particularly: Fishman, J. R., Klein, W. L., MacLennan, B. W., Mitchell, L., Pearl, A., and Walker, W. (1965). All of the authors listed have played a major role in the further development and expansion of the program.

[2] This program was supported in part by contract #3 T1-MH-8318-0381 with the Community Services Branch, National Institute of Mental Health, and in part by Training Center Grant #63215 from the Office of Juvenile Delinquency and Youth Development, U.S. Department of Health, Education, and Welfare, in cooperation with the President's Committee on Juvenile Delinquency and Youth Crime. Further development of the project was made possible through contract with the Office of Manpower, Automation and Training, U.S. Department of Labor, and the Office of Education, U.S. Department of Health, Education, and Welfare.

The striking outcome of this initial program led the staff of the Institute for Youth Studies at Howard University to expand the project and explore a variety of jobs involving work with people for which deprived, delinquent, and drop-out youths could be trained and hired. To date, over one hundred such youths have graduated from the program. A large number are working as classroom aides in elementary schools; others are involved in a detached worker program of the city recreation department. A group of nine is employed as youth leaders in a community-based mental health center for children and adolescents. Both young women and young men have been successfully trained to serve as aides in a number of the city's preschool and early childhood day-care centers, generally those geared specifically for the children of the disadvantaged. Another group is employed as counseling aides in welfare department institutions for dependent and delinquent children. Ironically, in several instances these institutions are the same ones or similar to those in which the aides had once been confined as inmates. Others are working in a geriatrics institution, in consumer education and youth organization projects of the local community action program, and in the research division of the local poverty program agency.

Many of the findings of the original project have been supported in these ensuing programs. The drop-out rate from training and, at least over the short run, from employment, has been minimal. There have been few instances of delinquent or criminal involvement, and none directly connected with the actual work setting. The effect of the program on the trainees has generally been one of raising personal and educational aspirations. A number of aides have gone on to prepare for and receive high school equivalency certificates; in some cases, they have enrolled in advanced courses in area colleges and other training institutions. Supervisors have been highly enthusiastic about the contributions of the aides to their particular agencies, with some of the aides already being raised to more senior positions in places with opportunities for advancement. Moreover, as in the initial program, most of the aides were chosen for training, almost randomly, from a pool of applicants. The attempt was to *include* as wide a variety of individuals as possible, rather than to *exclude* any particular subgroup on the basis of preconceptions about who, from this population, could or could not function successfully. Almost all attempts at predicting individual success or failure on the basis of intake interviews, test scores, school record, or other indicators have not worked out. Many youths who do not meet commonly held criteria for human service work often, and strikingly, "blossom" into highly effective aides when given the chance to show what they are capable of. We have written elsewhere (Fishman, et al., 1965, pp. 46-47) that: ". . . school performance, a delinquency record, and an erratic job history may, in the main, reflect difficulties in coping with problems in a particular kind of context, and thus may have little predictive value for behavior in a radically changed situation (one that is in many ways discontinuous with past experience and expectations)."

Who are these aides and why choose them for this particular kind of work? Some of them come with the more obvious "characteristics of the street": a reputation for leadership and/or delinquent prowess, a $70 sweater or a $30 pair of shoes (highly prized elements in one's "identity kit" when there is very little else to bolster status or self-esteem), a varied history of encounters with the law, and an erratic home and family history. Although there are often unique differences and almost as much variability in this population as in any other, a brief portrait of one of the aides should convey sharply the important features:

> Aide X finished the tenth grade at a Washington, D.C. high school before quitting school altogether. He is somewhat small in stature and, when first seen, his tendency to wear clothes one or two sizes too large only accentuated this fact. He gave the impression of being an extremely wary and guarded individual who hardly ever looked at or spoke directly to whomever he was addressing. In the early days of the program, he was quite critical of it, and openly questioned the possibility of its having any effect on the behavior of the group members. At the same time, he was quick to point out positive directions for action and to assume leadership. He is one of five children, and has lived for 17 years at the same address (a public housing project). His mother is a housewife, and his stepfather, a post office employee. In recent years, Aide X has tried to become more self-sufficient, at least in part because of a conflict with his stepfather. He has alternated between living at his parents' home, an aunt's apartment, and an apartment of his own. His employment record includes a series of low-paying, unskilled, temporary jobs, the most recent of which was as a one-dollar-an-hour kitchen helper. Aide X's delinquency arrest record includes charges of robbery and truancy. For both of these, he was confined to a correctional institution (Fishman et al., 1965, p. 14).

There are other, perhaps less obvious, things that the aides bring with them. Often central to their outlook on life is a feeling of, "That's the way it is, man." This brief sentence succinctly conveys their perception of a world that has very little to offer which they can attain and over which they are powerless to exert influence or control. They are suspicious of hope and possibility since they are all too familiar with how quickly such things can vaporize. Fate and luck are often prominent parts of their belief systems, at least in part because they see no rational way of interacting with the wider society and its widely advertised benefits. All of these things and more; a poor self-image, lack of future orientation, marked potential for antisocial behavior and impulsive acting out, and concrete conceptual ability have been ascribed to, and found in, these young people by many social scientists searching for clues as to what makes these youngsters different from their more aspiring, achieving, and stable middle-class peers. These observations have often led to the hypothesis that if, somehow, one could "get inside" and change these intrapsychic variables, self-concept, style of life, and behavior might also change. Thus, those who are not "in the same boat" as these individuals are called upon to provide the therapeutic, welfare, and rehabilitative services to help change those who are seen as not being able to help themselves.

What is often overlooked, however, is the large, sometimes overwhelming, reality component of the outlook and behavior described. To motivate someone to want to work and to hold down a steady job is a rather pointless effort if there are no jobs to be had, as is often the case. To convince someone of the importance of staying in school when there is little hope of going on to higher education and when one can see peers with high school diplomas standing on the same street corners as oneself is not the easiest undertaking. For these and other reasons, many of the attitudes and actions described above can be seen in a much more practical and heuristically valuable way. "Much of their 'aberrant' or 'delinquent' behavior . . . may be seen as a central feature of being increasingly relegated to the sidelines as spectators of society—a role that contributes very little to any kind of positive self-concept or identification. This dilemma molds a significant part of their social, psychological, economic and educational life" (Fishman et al., 1965, p. 2).

Posed in this fashion, the problem becomes one of finding *real* channels for moving these young people from their "outsider" and "spectator" roles (often elaborated with particular styles of life, norms, and values) into *meaningful* "participant" roles in society. What is also suggested is that the kinds of participation need not be limited to the hackneyed range of semi-skilled and unskilled vocational education type jobs that are usually offered, based on the assumption that people who demonstrate certain kinds of characteristics are best suited for such work. Pigeonholing of this type occurs because many of the young people we are talking about are generally unfamiliar with other kinds of work. If, as we believe to be the case, a major component of their behaviors and perceptions is a result of having continuously to find effective ways of coping with a particular set of social conditions, then there may be potential for their functioning meaningfully in areas which are different from those they are used to, areas which challenge and support them in new kinds of endeavors. This would be particularly true if the new roles, in themselves, contained avenues to heightened status and increased self-esteem by their very performance.

One obvious area in which such roles are to be found is what Pearl (1965) has called the area of "unmet needs of society," most notably the human services. Relatively unaffected by automation and directly related to population growth, these services, including education, welfare, recreation, child care, public health, mental health, and counseling services of all kinds, are already facing manpower shortages of critical dimensions. It should be noted that, as a group, they comprise many of the caretaker agencies and services which Duhl (1963) has pointed to as singularly important in the undertaking of a comprehensive mental health program. It is only a logical step, once having identified these needs, to place them in juxtaposition to the huge army of the alienated and unemployed who are desperately in need of meaningful, horizon-opening work such as can very easily come from giving service to a fellow human being.

It is out of such considerations that the concept of the human service aide has grown. He is a nonprofessional who, with some initial training, does those things which, in any helping service, do not require extensive education and background. By relieving the professional of more routine tasks, he helps the professional to do more of what the latter is uniquely trained to do. Thus, he may become the basis of a new approach to service that was formerly impossible because of a shortage of time or specially suited personnel. Of course, the emergence of the concept cannot hide the fact that contained within it are a wide array of complex and problematic issues, such as creating and defining jobs, providing for upward mobility and career lines, certification, orientation of professionals, and ongoing education. Each of the foregoing issues is dealt with more extensively elsewhere (Duhl, 1963; Fishman et al., 1965; MacLennan, Klein, Pearl, & Fishman, 1966; Pearl, 1965; Pearl & Riessman, 1965; Institute for Youth Studies of Howard University, 1966). Here, we will be largely concerned with the training of the human service aide: how it has been done, and what its significant features are. With some modifications and changes, the training model used in the first project has been implemented in all the ensuing programs.

THE TRAINING PROGRAM

The young people who are accepted for the project bring with them a wide variety of behaviors and interpersonal skills. Many of the latter are clearly designed to protect them from feeling responsible for themselves and for others, from the threat of being blamed for failure, and from the risk of making long-term, independent decisions about themselves and their futures. They are often quite expert at "proving," through goading authorities or professional staff, that their perception of "the way it is" is accurate and that the program is just one more variation on an exploitative, uncaring theme with which they are all familiar. This may take the form, at particular points of crisis in the training, of threatening to go back to the street to "rob and steal." Along with implied threats of violence, nothing could be more effective in raising a great deal of consternation among professional staff. The group leader of the initial project, for example, would sometimes find himself unable to adopt a consistent stand before these attacks, vacillating between trying to be supportive, helpful, and "well liked," and angrily wondering if a more demanding and punitive approach were necessary. Another gambit is what came to be called "the street argument." When these youths were faced with the possibility that they might have to give up some of their deviant and irresponsible behaviors in order to fulfill the more "square" demands of their new aide roles, they defended themselves by loudly protesting just how difficult this would be for them. Using a kind of naïve environmentalist approach, they would attempt to prove to the professional staff that "you don't know what it's like out there." Trainee after trainee might pick up on some particularly lurid account of the street, each one reinforcing and embellishing the other, with the whole tone of the meeting rising in pitch and tempo. The net effect rapidly becomes similar to what Raush and Sweet (1961) once labeled a 'verbal contagion" phenomenon, with the professional alternately fascinated and seduced by the stories he is hearing, or sympathetic and unable to think of a good counterargument.

THE CORE GROUP

Because of these types of behavior, it was decided that a central feature of the training program for the aides had to be some mechanism for working toward a change of values and attitudes. Part of the impetus for such change would come from the actual work in human services, offering as it does a sense of competence derived from doing meaningful work and having it recognized as such by supervisors, a feeling of making a useful contribution through the opportunity of seeing the relevance of their work to other people, and a way of exercising responsibility to people with, and for whom, one works. The problem remains, however, of translating feelings and experience into knowledge and generalizable concepts and using this to lay the groundwork for the development of norms, sanctions, and values adapted to the demands of working together with other people and performing satisfactorily in the human services.

The mechanism chosen in an effort to bring about relevant change in attitude and values came to be known as the "Core Group" (MacLennan & Klein, 1965), defined as:

> . . . a training group in which its members would learn how society, small groups, people in general, and they themselves felt, functioned, and developed. Within this group aides learn how to analyze personal, social and particularly job-related

> problems, make their own decisions, try on various roles and attitudes for size, and learn to cope more effectively with people and the world around them.
>
> Starting from their own experience, the members of the core group are encouraged to examine the processes of their immediate lives and the problems of living in a poor area of the city. As the group progresses, it draws upon experts to examine with it areas of knowledge of common concern to all. These include: problems of human development, i.e., family life, childhood, adolescence, normalcy and deviance; community institutions and resources; the special problems of the socially deprived; health care; labor and employment; the law and legal aid; credit unions, insurance and medical care; and general problems of working with people.
>
> . . . The business of the group is focused by a number of questions underlying all issues which the leader continually throws back to the members to grapple with—questions such as: How does one observe accurately and assess situations? How does one sort out alternatives and think through the consequences of actions? How does one judge what information is important and relevant? And how can one use others to help in this activity?
>
> Issues actually dealt with in the group cover a wide range, including: who is best suited for what job and why; problems of minority group discrimination; how to deal with annoying supervisors; rules and regulations about tardiness and pay; why someone is not able to feel a part of the project; and why the leader can be trusted more than group members. As far as possible, and within the limits of ground rules clearly set up at the beginning of the program, realistic decisions necessitated by these issues are left to the group. If the leader has to make a decision by default, then this itself becomes an issue for the group to take up (Fishman et al., 1965, pp. 18-19).

The core group, then, is a multipurpose instrument. In it, the trainee learns more about himself, the community, and the world he lives in. In addition it gives him a better chance to relate the specifics of what he is doing on the job to broader considerations. He also acquires basic training in those skills and aspects of knowledge that would potentially make him a useful addition to any one of a variety of human service positions. This includes observational and recording skills, use of supervision, pattern and function of community services, and interpersonal relations. Above all, his attention is being constantly focused on the "here-and-now" of his job performance, the problems and issues it raises, and their connection to his personal life, aspirations, and relationships with other trainees. As Empey (1966) has pointed out, it is this focus on the "here-and-now" that allows for the group members to interact with one another in terms of current ways of behaving or relating to people, rather than in terms of self-made definitions of what they once were like. In this way, stereotyped behaviors and expectations about the job, authority, personal future, and dealings with others can be reality-tested and broken down and a basis formed for a new kind of personal and group identity.

As put into practice in the training program, the young people who are selected meet daily for core group sessions ranging from one to three hours, depending on the topic under discussion. During the first half of the three-month program they meet five days a week; during the last half they meet twice a week. This is done to increase the amount of available time for on-the-job experience, which takes place the other half day, in anticipation of completing training and going to work full time.

The first week of the program is spent rotating through the settings for the various job possibilities (if more than one kind of aide position is being trained for). In those programs where only one type of job is available, the time is spent orienting the trainee to the work setting, the roles of professionals, dimensions of service, and the kind of work they would be doing. This aspect of training is provided for the trainees' information because many of these youth have little appreciation of either the range or content of jobs outside the narrow confines of what they usually look for (e.g., as maids, cooks, busboys, construction workers, garbage men, etc.). They need this time to become familiarized with the field, get oriented to administrative routines of the program, and establish the core group. Also during this period, and extending throughout the program, outside officials and representatives of community agencies and institutions are invited to talk about their work, particularly about how it relates to the kinds of things the aides will be doing and experiencing. This initial "widening of horizons" also involves taking the group on a number of visits to educational, social, and cultural institutions in the area. Following the orientation period, a regular schedule goes into effect of half-day, on-the-job experience, usually in the setting where the aides will eventually be employed, and half-day in the core group and instructional sessions.

Getting the group to function effectively is not always an easy task. It is not, after all, the aides' own idea, and there is no reason for them to come to the program with a ready-made sense of commitment. At first, they may seem to feel that, in order to get their pay (they receive a small training allowance during this three-month period), they must do as they are told and sit it out, even if it means long stretches of silence, frustration, and boredom. If the program appears to demand that they change their attitudes, then they are also prepared to tell and to give the staff what they want. They may often indicate that they are doing as much "problem-solving" on the program as the program is trying to do on them.

In the initial project, the group leader found that to sit with these young people every day for hours at a time can become a problem in itself. Days sometimes go by without anything of apparent importance to talk about and without some issue around which to make a decision. As if to find some comfortable and familiar way to spend the time, some "marginal" person in the group may often be singled out for the verbal attack of the others. The leader's attempts to ferret out the reasons for this may be misinterpreted as sanction for an onslaught. Yet all these actions become part of the task of getting the aides to adjust to their new jobs and to make meaningful decisions related to it, themselves, and the group.

On several occasions, for example, administrative errors and mix-ups caused the delay of trainee pay checks. The aides were furious, openly expressing their anger and cynical disappointment in the program and threatening to quit. The first time this happened, the leader anxiously responded to the group's reaction by calling in the Director of the Institute for Youth Studies. He offered to establish an emergency fund from which the aides could borrow money until they were paid. Five of the group accepted the offer, repaying the loan when their checks came through. In further discussion of this matter in the group, however, the other aides proudly said that they would never be in the position of having to ask the boss for money. Many of the group members told of how they had felt cheated of a chance to express their righteous indignation at the wrong that had been committed. The group as a whole, with the help of the leader, then began exploring ways of banding together so that none of them would again be caught in the position in which some of them now found themselves. When salary checks were delayed again a short time later, once more the threats of quitting, of going out to commit crimes, and the accusations of betrayal and lack of concern were heard. This time the leader did not jump; the group responded quickly by coming up with alternative plans of action, including the possibility of calling in a newspaper reporter and getting him to apply public pressure. The choice finally agreed upon was for the group to write a petition stating they would abandon their jobs in a body if they did not get firm assurance that they would be paid as soon as possible. Effective action was taken almost immediately, and the group had a firm instance of its own power and influence, as well as of its ability to act together for its mutual benefit.

One of the most significant instances of the youths' ability to make constructive use of the group situation, particularly when given the opportunity to make meaningful decisions, revolved around one of the girls in the group. Early in the program, she had been assigned to Research Aide training, given a tape recorder, and asked to interview some of the other aides. She had been given a "hard time" by one of the interviewees, leaving an undertone of resentment that carried over into the group sessions. Taking the tape recorder home with her, the girl did not return for three days. In discussing the issue, it became clear that the girl had always emphasized her higher socioeconomic background and remained aloof from the others. The boys in particular resented her attitude and had been looking for a way to "bring her down front" (demoralize her). Three alternatives emerged from the discussion and were presented as follows: (1) the police could be called and the girl charged with theft; (2) the leader could visit her and at least get the tape recorder back; and (3) the group itself could assume responsibility for the situation. The last alternative was decided upon, and it was left to the group to work out a solution.

Soon afterwards, the absent girl returned. The other aides had set themselves up in teams and waited at the girl's home until she returned, whereupon they had convinced her to return to the program. This same type of occurrence has now taken place in at least two of the ensuing aide programs. Again, the incidents illustrated how all the group members could mobilize themselves around the difficulties one of them was encountering, even when there were alternatives which might have relieved them of all responsibility. This is strikingly in contrast to the usual expectation of a lack of concern for others and difficulties in choosing among alternatives with these young people. In a similar fashion, during the pay incident, none of the members showed any marked inability to tolerate frustration or to delay for future gratification insofar as the program and their jobs were concerned (as might be signified by actually leaving the program, purposely doing poorly on the job, or reengaging in delinquent behavior). Given the setting, the opportunity, and support, the aides were able to express their anger within acceptable limits, to explore alternatives constructively, and to act in a unified and responsible manner. Just how permanent these behaviors can be is best illustrated by the following anecdote. Some weeks after the training program had ended, a professional social worker on the Institute staff experienced some delay in receiving her own salary and was angrily and loudly denouncing the administration while threatening some form of reprisal. One of the aides, who happened to hear her, walked over and patted her gently on the back, reassuring her with, "There, there. I've been through this before. It's just something you have to get used to."

The core group can also be a means of exploring and "imprinting" the dimensions of new roles and responsibilities, as well as of examining the implications of individual behavior in relation to them. In another training group (Klein, Walker, Levine, & MacLennan, 1966), the mood of the trainees began to change as the program moved into its second month. A kind of general apathy seemed to set in. Trainees were coming late, using the telephone for long periods of time, not completing assignments, sleeping in class, and generally manifesting behaviors suggesting that they were uninvolved with the program. In discussing this behavior with the trainees, heavy pressure arose from them for the training staff to be more authoritative, to set more limits and more rules and regulations so everyone would know what to do. They were given a detailed description of what would be involved should the training staff be obliged to take over and to make all the decisions, particularly as this would reflect on the trainees' ability to do these things. The group began to see self-discipline and responsibility as a preferable, if more difficult to attain, alternative. All the trainees were actively involved in this session and wanted more meetings of this type. They expressed pleasure, and not a little surprise, that their behavior and involvement was of serious concern to the training staff.

At a later date, a trainee with a history of alcoholic involvement engaged in some unbecoming behavior in the streets after working hours. The nature of the offense, some prior warnings, and other factors led to his dismissal from the program. When this decision was brought back to the other trainees, their reactions ranged from passive acceptance to open anger. Most of the discussion focused around the trainees' ambivalence about informing on another member and their covering this over by accusations of betrayal and irresponsibility on the part of the training staff. The latter refused to be pushed into an apologetic corner and insisted that a hard look be taken at the requirements of the program and the trainees' responsibility for their own behavior. The discussion gradually shifted to the nature and ramifications of "covering up" and whether it aided or impeded the process of individual and group responsibility. It turned out that several of the trainees had been "covering" for the one who had been dismissed when he had slept or been drinking on the job. Individuals in the group had long been aware of his behavior and had even tried to speak to him about it at various times. Their actions had, in an important way, affected the range of choices open to the administration of the program, as well as the image of the group in the eyes of the community.

These and similar discussions make up the life of the core group, with much of the content derived from the ongoing and parallel involvements of the trainees with on-the-job experience, one another, and the wider society. Parenthetically, it should be obvious that the role of leader for these groups is both complex and not a very favored one for hiding or ducking issues. He is not there as a group therapist, a role which is a great temptation for the contemporary professional. Instead, his role involves a great deal of personal risk and willingness to offer his own actions, values, and abilities as models to be emulated. This includes the possibility that many of these may be found wanting and will have to be replaced by others, both for the leader and the trainees. Moreover, the leader must be able to tolerate the foundering, indecision, and lack of closeness that often characterize the group, indicating by his demands for competent performance and lack of anxious intervention that in *this* group decisions *can* be made, problems *can* be solved, and individuals *are* going to "make it." He is less concerned about what he can do to, or for, the youth than he is about how to work with them toward their becoming active participants in a process of mutual regulation, problem-solving, and growth. Significantly, it is not only the highly trained professionals who can serve as this kind of leader but also young adults, often with the same backgrounds as those of the trainees, who have been trained to function in this capacity (Klein et al., 1966).

While the core group constitutes one part of the training process, a second significant element is specialized skill instruction in the particular field for which the aide is being trained. Usually, four to six hours per week are set aside for instruction by specialists in the various skill areas. The primary goals of this instruction are the following: to provide the aide with some skills that he can begin using immediately on the job so that he does not have to remain too long in the role of passive observer; to lay the groundwork for the aide's educational and professional advancement by inspiring him to improve himself and by providing the prerequisites necessary for advancement; to make the aide a more valuable worker to his particular agency. The crucial feature of this instruction is its link with on-the-job experience. Questions and problems that arise in the work situation are brought back to the classroom, where they help to determine the range of content material to be covered. Conversely, what is taught in the classroom can be almost immediately tried out in the job setting and reinforced through actual performance.

In Research Aide training during the initial project, for example, the two aides assigned to this specialty were first given instruction in interview techniques and in the use of tape recorders. They then conducted an interview as part of their work assignment. The interview was critically reviewed in the presence of the instructor and suggestions were made for improving technique. Each successive interview was given the same treatment. In like manner, the aides were taught some of the basic techniques of controlled observation and then immediately assigned to do this. Again, these observations were brought back for critical review. After some proficiency had been gained, the aides were taught systematic ways of coding and analyzing observation data through the use of Bales' model and sociometric analyses. In order to deal with these data, they then learned some simple statistical computations and the use of the calculator. As can be seen, almost every element of their instruction was tied to an actual and meaningful task, with each unit built on what had previously been learned and the demands of the work situation.

ON-THE-JOB EXPERIENCE

The instructors of these specialty classes generally have a clear idea of the range of content material that they want to cover, but they are continually alert to the possibilities of using situations that arise in the course of work experience for introducing new concepts or skills. In training aides for work in child care settings, for example, there are a number of areas that need to be covered: principles of human growth and development, techniques for managing problem children, recognition of emotional problems, the meaning and function of play, observational skills and techniques, games and preschool activities, and parent contacts. When, at what level of complexity, and in what fashion these are taught is dictated by a combination of what supervisors feel the aides need to know to be most useful, actual problems that the aides are encountering on the job, and how much prior experience the aides have had with the concepts and issues involved. The notes of the child care instructor give some graphic illustrations:

I explained what a case conference was, what you needed to know, how you would have to be able to present material, etc. (the aides had been invited, a few weeks after beginning their on-the-job training, to participate in professional staff conferences at the child care center). They were very interested in this, and eager to go on and present the observations they made in response to my assignment to them (including the child who was to be presented at the conference). Some had written them, most had not, but all had certainly done the observation. I pointed out the need to be able to write them down in the future . . . but I felt we ought to bring out some of their difficulties in doing so. Aide Y said how confused she got when she was trying to watch one child and another began playing with him, how she couldn't write as fast as she could think, etc. We practiced a few of these . . . I said I also knew some of them had had trouble with writing and spelling and stuff like that in school, and wondered if perhaps they were afraid of making mistakes, reassuring them that mistakes wouldn't bother me. I asked if they wanted me to point out spelling errors and they all said they did, Y adding that this was a way not to keep on making the same mistake (this eventually developed into a series of remedial English classes for the aides) . . .

. . . The coffee fixed and served, we went into Aide X's report on S (a child in the child care center). He had answered each of my questions with a sentence, had had the wit to add that S seemed to want to play with one little girl exclusively, had done a fairly good job of observation, but the English was execrable. We talked about how the mother is with S. Aide X had noticed that she didn't let the child take her own outer clothes off and the kid wanted to do it herself; also, that the child controlled the mother. We went into what might make the mother this way, and I found myself needing to get across the concept of the unconscious, so I waded in—using as example (not exactly accurate but I got the point across) the fact that sometimes when one meets a person, one feels instant like or dislike, and tied this up with past experiences with brothers, fathers, etc. They got the point right away, Aide W commenting that sometimes one feels as if one had met the person before. I stressed the influence of one's childhood and the people in it on future behavior, and then went into a woman's possible unconscious need to keep a child a baby, and why, using an example of how I felt when my only kid went away to school. They were very interested in this, and added comments of their own—X commenting at one point that he would like to hit the child S sometimes when she was so mean to the other kids. I brought in the fact that S was an angry child, and we tried to get at some of the reasons and results of this. X was extremely interested.

. . . We got down to the business of playing with blocks. I showed them how they should be stored . . . how they were modules of one another and how the kids learned shapes and relationships and even rudiments of fractions by playing with them, but even more how much fun they had playing with them. They went to work to build—Aide W with alacrity and his usual creativity, making a nice castle; Aide X more slowly and having to overcome some shyness; Aide Z not at all for a while. . . . I said, "This is the kid who won't enter into the block building; how do we get her into it?" I took Z's hand and asked if she wanted me to help her get started, just as if she were a kid . . . I showed them what kids do to each other's buildings, how to handle situations where they kick down each other's buildings, etc. (Fishman et al., 1965, pp. 31-32).

These notes give some indication of the varied armamentarium that the specialty instructor can bring to bear on the content material: straight lecture, group discussion, exploration of personal and work experience, role playing, participant workshops, films, etc. Experience in this program has repeatedly demonstrated that a great deal of interest and enthusiasm to learn can be generated in these "unmotivated" and "anti-intellectual" disadvantaged youths when they can see the relevance of what they are learning to their increased efficiency and competence on the job, and when they have an immediately available forum for bringing up problems and raising questions about what they are doing.

This leads to what is often a common fallacy in working with, training, and employing these youths. An erroneous assumption of how much, or how little, they can grasp of the technically complex and intellectual is based on the presenting styles of these young people (concrete, down-to-earth, action-oriented). The problem lies much more in the presentation and relevance of the material, as well as the expectation presented of what they can learn, than in anything intrinsic to the capabilities of the aides. In one group being trained for work as counseling aides in welfare institutions, the trainees very quickly became caught up in questions of institutional roles, the effects of institutionalization, staff morale, and reasons for high recidivism rates. This was something they were experiencing in an immediate, often painful, way in their on-the-job training, and no amount of "just do your job and forget it" advice was going to alleviate their concern. The instructor for their Human Growth and Development sequence shifted to a consideration of some of the ideas about institutions and their structures and effects as developed by such investigators as Stanton and Schwartz, Goffman, Henry, Bettelheim, and others, stressing the major concepts and illustrations in as direct and nontechnical a manner as possible. No readings were required, since very little of this kind of material exists at a reading level that would be useful for the trainees (an experiment at "translating" portions of one of the authors into simplified English, however, was highly successful). With very little guidance, the trainees quickly were able to see the relevance of these ideas to the kinds of dilemmas and problems they were facing. Soon afterward, in a classroom exercise, they applied some of the principles they had learned to analyzing the structures and programs of the institutions at which they were training. One of the more positive outcomes of this exercise was that the trainees began to derive strategies for "staying alive in the system" while helping to work toward the improvement and modification of the program.

The same kind of fallacy noted above often turns up in deciding what the aides should do in their job assignments. It has been a principle of the Institute's training program staff, working jointly with the staff of the agency for which the aides are being trained, to prepare as complete a job description of what the aides will be doing and should be able to do as is possible.

This description outlines tasks which can be performed with a minimum of training and which the aide can start doing almost immediately after the beginning of the training period. It *also* contains tasks that may require lengthy training or may depend on abilities and qualities of the individual that become visible during his work experience.

The word *meaningful* has often been used in this chapter to describe our concept of the work for which human service aides can be trained. To restrict their duties to only routine, menial, and housekeeping tasks is to confirm their worst expectations of what this new job really is. Such an orientation would provide little opportunity for the kinds of experiences that can be capitalized on for additional learning and training. Moreover, it denies the agency in question a chance to see what the aides are capable of and to use them in ways that may be more directly beneficial to the service being offered.

The job description, then, at best should provide a series of tasks graded in terms of demonstrated responsibility, competence, and knowledge or ability prerequisites. It need not be a fixed document, but can be modified as experience and practice dictate. This is all the more important when we realize that the use of such aides is new and relatively untried. Each project in which aides are utilized will, for some time to come, be in the nature of a demonstration. We hope through such projects to be able to answer questions such as "*who* can do the job?" and "what kinds of things can be done by a particular group in a given setting?" The accumulation of such data becomes one of the more important tasks for the future.

SUMMARY AND CONCLUSIONS

The three major components of the training process have now been identified as: (1) the core group, including basic training in what can be described as generic human service skills, (2) specialized skill instruction, and (3) immediate on-the-job experience. It should be clear from the foregoing presentation that each one of these components is designed to complement the others. Each derives its significance and impetus from the other two.

Some of the problems and issues that arise from trying to achieve an integration of program elements have already been suggested. Perhaps the simplest guiding principle for successful integration is contained in the notion of *flexible and self-critical programming.* There is a need to be flexible in the sense that because this is a new kind of approach, there are very few available guidelines or experts. The training program must be responsive to changing needs, and it must be organized in such a way that those internal changes that are required may be made rapidly. Our use of the term *self-critical* is intended to underscore the necessity that the program be set up and kept open to receive continually informational feedback about what is going on in its various components. Thus problems can be confronted immediately, rather than being allowed to fester. In this way, the program does not end up being something other than what it was planned to be, often with the resentment and consternation of both professionals and trainees. This also allows for new and unpredicted needs to be recognized and potentially dealt with. The issue of remediation for the trainees, for example, grew out of their own recognition of shortcomings in reading and writing abilities and led to the creation of remedial classes, as well as to the exploration of new ways of combining aide training with academics. The Institute for Youth Studies is, for example, now cooperating with a local high school in an experimental venture for turning their school year into an aide training program for thirty disadvantaged high school seniors.

The initial training that has been described above should be seen as just that—a first step designed to take youths who have often been defined in negative or even pathological terms and to train them to help render many of the same services often prescribed for them. Although it clearly has rehabilitative and therapeutic features, the primary aim of the program is to tap effectively a huge, generally overlooked source of manpower for the human services. We would make a serious error, however, if we were content to stop with this—to create, as it were, a new kind of attendant or day laborer who would just as irremediably be fixed where he is as is the ditchdigger or the janitor. Some of the youths will choose to remain at a fairly low level of a particular occupation. Others, however, must be given the chance to advance educationally and professionally, without having to "give it all up" in order to reach professional status. In order to accomplish this, changes, many of which are still in the early stages of conceptualization, will have to be made in patterns of employment, education, and human service. To refine and implement these ideas further, we also need the kind of new professional that Reiff describes elsewhere in this book, not only for program planning and institutional modification but also for training, supervising, and most effectively utilizing the new cadre of human service manpower represented by the aides and other nonprofessionals.

All of this is part of the critical task for the future, if we are to sustain the momentum and enthusiasm reflected in these observations of a seventeen-year-old, tenth-grade dropout, now working for almost two years in a child care center. The grammar is not the best, but the meaning is clear:

> In Day Care, I have learned many ways of handling kids. I also have learned how to cope with kids with home problems, shy, the ones that don't talk very much, the ones that get along with the rest of the group, how to play or what to play with on a rainy day. In working with small kids you should know their backgrounds, like where they come from, where did their parents come from, what do their parents do, are they living with their mother and father, or are they staying with their mother alone, or with their father alone, whether they were born in the District or elsewhere, what kind of environment do they live in now?
>
> You have to learn how to talk to a child, and what to say to them, how to

> say it. You should learn how to firm grip a child and you will have to learn how to give a child a lot of attention and find out whether he or she really needs it, or whether they just trying to get it whenever they feel like it; you can't give all of your attention to one child; it is alright to play with the kids but you must let them know that you are the teacher, and they must stay in their class and you in yours. . . .
>
> Some of the reasons why I like Day Care, being with small kids and on the other hand working, it gave me some kind of feeling; watching and playing with them makes me think of my past, of some of the things or chances that I did not have when I was coming up. Sometimes while you are playing with the kids you let yourself get carried away, you think of some of the things that you missed when you were coming up. And then you get hold of yourself, and remember that you have a job to do, for I say to those that do not work in Day Care or don't like to work in it they don't know what they are missing. I think that it would be better if more men were teaching in Day Care Centers. . . .
>
> . . . I know that some of us grew up the hard way or some came up easy way, but it seems like mine was the hardest, if I told you the way that I came up you won't believe it, but ever since I got this job I have learned and enjoyed every day of it. (Fishman et al., pp. 59-60).

Put as concisely as possible, the human service aide program represents one aspect of a major attempt at intervention into ongoing problems of manpower, patterning of services, and therapeutic effectiveness. Programs such as the one described in this chapter can provide a readily trained reservoir of personnel for the fields of human service. Moreover, they offer a combination of training, rehabilitation, and realistic employment that is strikingly effective for a population that has long appeared resistant to traditional approaches. It must be emphasized, however, that dealing with immediate manpower shortages, no matter how exciting the project is itself, can be an easy way of short-circuiting serious exploration of new concepts and approaches. An appearance of change and movement can be approximated, while it is only vacant job slots and service needs that are being filled.

The significance of the aide program will be lost if we allow the important fact of who the aides are to obscure the wider issues. The creation of human service aide positions is only one aspect of efforts to reorganize existing program structures and institutions in line with new perspectives on community mental health, organization, and involvement. Seen in this light, the human service aide has the potential for becoming either one of a number of gimmicks that are bound to appear in a period of reorientation or an occasion for serious planning, conceptualization, and research. Under the impetus of various new possibilities of federal funding and programs, the kind of training and manpower development described in this chapter is already being experimented with in a number of communities across the country. Hopefully, these projects will not be content merely to demonstrate the efficacy of training the aides but will also come to see such programs as a major tool for investigating some of the more pressing issues of our time.

REFERENCES

Duhl, L. J. (Ed.) *The urban condition.* New York: Basic Books, 1963.

Empey, L. T. A social systems approach for working in small groups with socially deprived youth. Paper read at American Group Psychotherapy Association, Philadelphia, Pa., January, 1966.

Fishman, J. R., Klein, W. L., MacLennan, B. W., Mitchell, L., Pearl, A., & Walker, W. *Training for new careers.* Washington, D.C.: President's Committee on Juvenile Delinquency and Youth Crime, 1965.

Institute for Youth Studies of Howard University. *Training non-professional workers for human services: A manual of organization and process.* Washington, D. C., 1966.

Klein, W. L., Walker, W., Levine, M., & MacLennan, B. W. *Leadership in the training of human service aides.* Washington, D. C.: Institute for Youth Studies of Howard University, 1966.

MacLennan, B. W., & Klein, W. L. Utilization of groups in job training. *Int. J. group Psychother.*, 1965, *15*, 424-433.

MacLennan, B. W., Klein, W. L., Pearl, A., & Fishman, J. R. Training for new careers. *Comm. Ment. Health J.*, 1966, *2*, 135-141.

Pearl, A. New careers—an overview. In J. R. Fishman, B. W. MacLennan, & A. Pearl (Eds.), *New careers: Ways out of poverty for disadvantaged youth.* Washington, D. C.: Institute for Youth Studies of Howard University, 1965, Pp. 10-23.

Pearl, A., & Riessman, F. *New careers for the poor.* New York: Free Press, 1965.

Raush, H. L., & Sweet, B. The preadolescent ego: Some observations of normal children. *Psychiatry*, 1961, *24*, 122-132.

10

A NEIGHBORHOOD-BASED MENTAL HEALTH APPROACH

Frank Riessman

Formerly, Director, Lincoln Hospital Mental Health Aide Program[1]

INTRODUCTION

The under-utilization of mental health resources by low-income populations has been attested to in a variety of studies beginning with Hollingshead and Redlich's classic *Social Class and Mental Illness* (1958). A number of factors have been suggested as contributing causes: high cost of services, lack of availability of services, failure of low-income populations to define distress in psychologically relevant terms, attitudes of low-income people toward mental illness, fear of institutionalization on the part of the poor, and finally, the middle-class character of the mental health movement and the associated inappropriate nature of the services offered to low-income people. Stated another way, the present day organization of mental health resources is primarily congenial to middle-class style and expectations. It has been noted that low-income individuals often believe their problems to be externally produced or physiologically caused. They expect mental health clinics to provide drugs and clear-cut directive advice. Their focus is more on present, crisis-related problems. They prefer that help be given in a more informal fashion. The setting of the office, the futuristic orientation, the stress on self-actualization found in the mental health movement is not congenial to them. With these factors in mind, most of the recommendations that have been directed toward working with low-income populations have been mainly concerned with matching services to their style and meeting their expectations, while less emphasis has been placed upon content and program.

The *style match* approach is oriented toward "reach" and communication. It is an effort to meet the low-income person on his own "turf" and to utilize this person's style (and strengths) as a basis for working with him.

Other than style match, there has been some developing concern with what might be called *style and skill expansion;* thus a number of programs, particularly in the counseling area, have recognized the need for expanding coping techniques, know-how, verbalization, and other related factors among the poor. The use of role playing for stimulating verbal development is illustrative. But until now most of the emphasis has been on style match and meeting the expectations of the low-income person, with little emphasis on content or goals. This has, in most cases, been justified because of the danger of imposing middle-class goals on the low-income population. It may be entirely possible to develop goals and programs that are consistent with the development of low-income life without necessarily "middle-classizing" the people involved.

---

[1] Currently Professor of Educational Sociology, New York University.

THE NEIGHBORHOOD SERVICE CENTER

The Neighborhood Service Center (NSC) program to be outlined below attempts through structure, personnel, and *program* to integrate the many different proposed approaches to low-income population; but it endeavors to go considerably beyond style match and even style expansion. The NSC escapes the office atmosphere, shortens intake procedures and makes them less formal, has no waiting list, accepts any problem in any form, does not require continued visits, catches people at the point of crisis, uses treatment agents recruited from the population itself who can be informal, personal, and friendly. It helps people with concrete, present-oriented problems and provides directive advice and assistance (i.e., it does not demand that the individual do it himself). Its staff is willing to make home visits at any time and participates in all types of activities including funerals, outings, helping people to move, and extinguishing fires in apartments. Recording of information and contacts is kept to a minimum. Talk and concrete help are combined. The NSC attempts to expand the know-how and coping ability of its clients. The NSC emphasizes group approaches yet has available hospital-based mental health clinics, with doctors and drugs as a backup resource. It stresses social activities and, finally, is concerned with developing a well-organized action program, one that is not only therapeutic but fundamentally concerned with problems of the neighborhood—drugs, violence, jobs, institutional changes in the service-providing agencies. This last provides a unique aspect which goes beyond most previous approaches. In essence, the basic strategy of the program represents an attempted integration of community action and preventive approaches to mental health problems.

The NSC program is a structural outgrowth of the Lincoln Hospital Mental Health Services. The community served is a highly disadvantaged one located in the southeast section of the Bronx, a borough of New York City. Not only is the population economically deprived but there is a marked dearth of services available to it. Compared to the Bronx as a whole, most of the Lincoln area falls into the lowest quartile of median family income ($3700-$5400) and educational attainment (7.6-8.8 years) and the highest rate of male unemployment. The rate of unemployment in this area is approximately twice that of the Bronx average. Similarly, the amount of overcrowded housing and school facilities is about twice that of the Bronx as a whole. In addition, compared to the Bronx as a whole:

1. Rates for juvenile delinquency offenses are 25% higher.
2. Rates of venereal disease among youth under twenty-one are three times greater in some neighborhoods of the Lincoln area and one and one-fourth times as high in other areas.
3. The rate of public assistance cases is approximately twice as high.
4. Admission rates to state mental hospitals are 40% higher from this area.
5. Although reliable figures are not available, estimates of the percentage of deliveries of the Lincoln Hospital Obstetrical Service in which there is no legal father run as high as 70%. Comparable figures for the Bronx as a whole are not available.

The NSC is a storefront, functioning at street level. Each center is staffed by five or six indigenous nonprofessionals from the neighborhood and one professional mental health specialist or NSC director. The center is intended to serve a radius of five blocks (approximately 50,000 people). Because of its storefront character, the center is easily available to area residents; in addition, staffing of the center by nonprofessional mental health aides makes for easy access by neighborhood people from the disadvantaged area.

The NSC is seen as a basic new unit in a community mental health program devoted to preventive intervention. It is conceived as a structural innovation in community mental health programs. Within this context, the NSC has the possibility of serving many different mental health roles at numerous levels. It can even function primarily as a clinical adjunct directed mainly toward secondary and tertiary prevention. In this sense, it might be more accurately described as a neighborhood-based mental health clinic.

The preventive community approach of the NSC program is primarily related to its two sources of support: the Lincoln Hospital Mental Health Services, funded by the Department of Hospitals of New York City, and the Community Action Program of the Office of Economic Opportunity. The mandates provided by these two sources of support have been considered in defining both the goals and programming of the NSC. One emphasis, for example, which suggests itself—the development of autonomy, independence, self-determination, and coping skills among neighborhood residents—would seem to combine elements that are clearly related to both sources of support. From the positive mental health viewpoint, autonomy is a primary objective, in the sense that Jahoda (1958) uses this concept in her survey of mental health principles. Likewise, the anti-poverty program is committed to community action projects which are oriented toward the development of self-determination and autonomy on the part of the individuals and groups in the community.

It is important to attempt to specify more clearly the mental health focus of the NSC program in order to understand the selection of activities and specific programs. We have already said that the larger mental health goal of increasing autonomy is central to the NSC design and, thus, programming must develop in consideration of this objective. It is in this context that the significance of group services is stressed. It is hypothesized that group life directed toward certain meaningful, achievable goals instrinsically contains significant mental health components. The experience of working together, sharing, cooperating, and objectifying problems is vital to rehabilitation, increasing feelings of strength, and reducing helplessness and alienation. How groups are formed, developed, and utilized, of course, can make a great difference in the achievement of autonomy and in the decrease of helplessness. The use of the helper principle may be of special importance. Here people are consciously placed in a helper role not only to aid other people but for the development of the helper himself: increasing his leadership, coping ability, self-image, etc. (Riessman, 1965a).

THREE GOALS OF THE NEIGHBORHOOD SERVICE CENTER

The three goals of the NSC program are, in actuality, means toward larger mental health goals; and in this sense, they might more accurately be considered subgoals. The larger mental health goals relate to increasing positive mental health and reducing negative mental health by limiting, containing, and controlling pathology and its development.

The three goals to be discussed are not presented in any order of priority, but rather in the time sequence in which they are likely to be developed. Thus, goal number one may overlap with the later goals, but it will be emphasized primarily in the early stages of the program. Goal number two will be developed at a later point and is based upon some measure of success with regard to the earlier goal.

The three goals are as follows:

1. Expediting and providing services relevant to mental health. This includes bringing new clients into the system of services, making service systems more responsive to clients, and providing additional new services.
2. Increasing social cohesion within the concentration area. An effort is made to produce community impact, particularly with regard to the development of various types of groups leading to the development of community action. Thus, the effort is to provide a sociotherapeutic

approach oriented toward reducing powerlessness, building community ties, and group involvement.

3. Initiating various types of institutional change, particularly with regard to better coordination of services for the people in the community. An effort is made to change agency policies and practices with regard to service delivery and the development of comprehensive mental health services. This is a long-range goal and it is more connected, than are the first two goals, with other programs in the Lincoln Hospital Mental Health Services complex.

In the sections that follow these three fundamental goals and their concrete mode of implementation will be discussed in considerably greater detail.

Service and Preventive Intervention

It is possible to conceive of a preventive mental health model that did not begin with individual services but proceeded directly to the development of groups or other efforts at building community action. In the present NSC design, however, individual services provide the entering wedge. It is through individual services that the target population enters the system. The target population is that segment of the poor who have been least active, are in greatest need of service, and are not responsive to militant social action appeals. We believe that through a service-oriented program beginning with service to the individuals, many of these individuals can be encouraged first to participate in informal social groups, later in more formal service groups and task-oriented groups, and finally, in various types of community action and intergroup activity. This sequence will be described more fully below. It should be underscored here, however, that we believe that it is necessary to begin with the service needs of the population in question.

While service can be viewed as an instrument to the other ends of the NSC—institutional change and community action—it is also necessary to clarify the importance of service as an end in itself (or as a major means for improving mental health). Well-delivered service may provide increased comfort, reduce strain, and perhaps most significantly, prevent the development of cumulative stress. Langner and Michael (1963) hold the view that psychiatric disturbance is related to the number of stresses operative upon the individual. Thus, a service program designed to reduce stresses should have implications for mental health, both in the reduction of pathology and in the increase of positive mental health. Within this framework, the NSC is conceived of and presented to the community as a place where people can bring any type of problem. This is extremely important. It allows people the possibility of receiving immediate help and comfort without having to define the problem in a way apropriate for the caretaker or care-giver in the help-giving system. By so doing, it allows the individual some immediate assistance before the problem becomes aggravated and perhaps develops into less reversible pathology. It allows for catching a problem in its early stage of development. Further, it enables the mental health system to deal with problems before they become symptoms, and it does not impose upon the client the need to develop symptomatology in order to receive mental health assistance. Moreover, it does not require that the client label his difficulties as sickness or mental problems. Low-income clients, in particular, have not been responsive to so labeling themselves. Aside from the negative overtones involved in having a mental health problem, being defined as sick, as such, has regressive implications for the client; and to the extent that he can be assisted with his problem without it being defined as sickness, the ego-weakening properties related to being defined as ill are reduced.

It is our contention that the very nature of the NSC will enable the individual to define his problems in a more everyday fashion and to be less apt to conceive of himself as sick. This, of course, requires not only the existence of the NSC but such an orientation by its personnel.

It is clear, then, that a service-oriented approach of the NSC is basically related to primary prevention. The orientation to service includes:

1. Direct provision of service to clients—escorting of clients, giving information, filling out forms, writing a letter.
2. Expediting service from other agencies.
3. Integration and coordination of services (since the NSC can deal with multiple problems either directly or by expediting service from other agencies).
4. Referral and follow-up.

The service orientation, to be most effective, has to be integrated with other dimensions of the program, such as the community action aspect. These approaches should not be separated from each other as they were, for example, at Mobilization for Youth (Riessman, 1965b). Such bifurcation limits both the role of service and the role of community action. Many people receiving service have excellent potential for forming groups, perhaps service-oriented groups at first and later, task-oriented groups moving toward larger community action.

Service groups are composed of people with a shared service need, e.g., a group of welfare clients who experience inability in managing on a limited budget might form a group that discussed purchasing, where and how to shop, etc. Task-oriented groups are focused toward community issues of a broader kind, not simply immediate service needs of the participants. For example, a committee organized to establish after-school centers or to convert a vacant lot into a playground is a task-oriented group.

The service emphasis of the groups will provide an input of specific community demand into the community action approach. Thus, it is unlikely that the community action program will develop goals, such as those that developed at Mobilization for Youth, which are not related to the immediate, voiced needs of the population receiving service. Mobilization for Youth developed rent strikes and school boycotts which, while they may have quite well reflected the long-range needs of the people in the area, were not related to the immediate service requests of the population that was being served. The latter is clearly the focus of the NSC.

Thus far, the services that have been discussed are what might be termed nonspecific mental health-related services. In addition, however, the NSC program provides more specific "psychosocial first aid" and counseling of a simple type. In the early phases, this counseling consists largely of providing a listening ear and some emotional support. The skills involved are based on enlarging the friendliness and warmth believed to be characteristic of the neighborhood worker's style. The nonprofessional's basic pattern of relationship is not "trained out," so to speak, but is expanded by training appropriate for the rather primitive counseling to be provided at this stage. Later, this counseling skill can be expanded so that mental health aides may be able to assist clients in problem definition, in the consideration of alternatives, and in giving advice and guidance. In addition, the mental health aide is made aware of the fact that, in providing all types of concrete service, it is important to enable the client to talk fully and freely about his problems; that is, to provide an opportunity for catharsis and to furnish the personal emotional support that is so valuable. Thus, a psychological service is built in as a concomitant of most other services.

It is unlikely that the provision of counseling and psychological assistance will ever become separate from other services in the NSC framework. Multineeds are typical of the population, and multiservices are offered. This is quite different from the more traditional mental hygiene clinic where psychological service is often isolated from other types of concrete help. In the NSC the rule is the combination of services, and it is rare for psychosocial first aid or counseling to be furnished independent of other services. We believe this is a particularly appropriate pattern for a low-income population and that counseling and mental health services are much more acceptable in this context, particularly as provided by nonprofessional neighborhood "friends."

An important dimension in furnishing service at the NSC is to have the nonprofessional mental health aide provide an appropriate model to the client or customer. The program encourages the client to become involved in a mutual and reciprocal relationship with other people who are also in need of help. People are encouraged to help each other and not simply to receive help. The aide has to be trained to present this model and to encourage this form of interaction and development. He has to be constantly on the alert to transform helpees into helpers, and basic community norms must be built that emphasize communality, mutuality, and reciprocity. In this connection, Weissman's[2] approach to developing service-giving power and technology in the people who come for service is extremely important to consider. Weissman envisions the provision of service as the first step in teaching the client how a service system operates. His aim is to give the client the ability to administer services (e.g., filling out housing forms) and to expedite services. Weissman is concerned with providing elements of service-giving power to the members of the community, and thus he argues that service is rarely to be given without also teaching the client the machinery of service and even how to teach the service operation to other people. Obviously, this does not apply to all people coming for service; but where possible, it may be a related goal of considerable significance and may greatly strengthen a service orientation.

Past Failures

It is important to note that most individual service programs developed by social agencies appear to have been relatively unsuccessful with low-income populations. We suspect that there are probably a number of reasons for this:

1. Service was not articulated with other approaches (e.g., community action). The debilitating stigma attached to receiving help was typically not counteracted by a community action self-help orientation, focused on the developing of power by the low-income individuals receiving help.
2. The service approach did not focus on specific targets, neighborhoods, and problems. It did not concentrate sufficiently on a circumscribed area, but rather attempted to provide services for the community as a whole; hence, impact was minimal. By "keying" on a more limited five-block radius, it may be possible to maximize service effectiveness.
3. Service was defined too narrowly; the need for new forms of service and group service approaches was overlooked.
4. Little attempt was made to integrate and coordinate services—the special importance of the expediter role was ignored.
5. The services were too middle-class oriented and not within the reach of the low-income populations. They were not intended for, and were not presented in, a style appropriate for these populations.

By way of overview, the service approach in its fullest sense may not only reduce stress and contain pathology but should also produce additional strengths in the community and increase positive mental health in various ways. However, an NSC program which is simply service oriented will probably be limited. It is only together with other forms of intervention that the maximal potentialities of the service approach can be harnessed. We begin with a service approach because people who are most in need of service and least responsive to other types of appeals are our main target among the disadvantaged population; however, our aim is to go far beyond this entry point.

---

[2] Personal communication.

A more concrete picture of the service function of the NSC program can be obtained by a brief look at some of the statistics gathered in the first six weeks in which the first center was operative. Of those people seen, approximately 70% were women, 69% were Puerto Rican, 18% Negro, 13% non-Puerto Rican white. Fifty-one per cent were walk-ins, 16% were referred by other agencies, 19% were referred by families or friends, and 4% were referred by Lincoln Hospital. The main areas in which service was requested were housing 25%, welfare 22%, employment 23%, and family problems 8%. With regard to disposition, 39% of the cases were concerned with information and referral, while 49% involved direct expediting.

Looking at our statistics over a somewhat longer bloc of time, we can report the following. From February 22, 1965, when the first center opened, to December 31, 1965, 7,119 different people were served by two of the centers. During the six-month period (July-December) when both centers were in full operation, 6,620 new cases came for service—an average of 1,037 cases per month. Projecting these figures for a full year's operation gives a total of 6,220 individuals *per year per center*. The size of the average family coming to the center is 3.9 persons. Thus, it is not unreasonable to state that, indirectly, each center touches the lives of some 25,000 people; and this does not include the many hundreds more who have become involved with the center through the various community education and action campaigns.

Based on these statistics, it appears that the NSC is an excellent device for reaching a large proportion of the residents in the area it is designated to serve. Though experience with the centers is limited, findings to date are most encouraging. It seems fairly clear that nonprofessionals can provide and expedite service for large numbers of disadvantaged families. Moreover, it is evident that nonprofessionals can intervene in critical situations, engage comparatively pathological people in meaningful relationships, stimulate them to take action in their own behalf, mobilize community resources, and serve as a bridge between the client in need and the professional service. The nonprofessional is able to perform some tasks that are usually carried out by professionals but really do not require professional training and experience. In this manner, the outreach of the professional service is expanded, and considerably more people can be affected than would be possible by using professional personnel alone.

In sum, then, it may be said that the service approach emphasizes, in the main, the "supply" aspect of the problem. It attempts to provide a more efficient, better integrated caretaker supply of resources for the client. It endeavors to connect the person with the service more efficiently via its expediter dimension. It is not concerned with the development of consumer demand and community action. It is to this latter objective that the second major goal of NSC is directed.

Community Action

A point of historical contrast between mental health and social action models is that the former have functioned primarily within formal and existing institutional structures, whereas the latter are more likely to deal with informal elements of the community at large, to activate large numbers of individuals, and to energize self-helping orientations and self-improvement. The social action approach activates pressure, militant or otherwise, from outside (Peck, Kaplan, & Roman, 1966).

It is interesting to note that Caplan (1964), whose preventive psychiatry framework has provided much of the conceptual base for the present chapter, defines social action in terms of affecting administrative policy:

> Social action is the name given to efforts to modify political and social policies and legislative and regulatory actions in the health, education, welfare, correctional, and religious fields so as to improve on a community-wide scale the provision of basic physical, psychosocial, and sociocultural supplies and the organization of services to help people cope with crises. The mental health specialist offers consultation to legislators and administrators and collaborates with other citizens in influencing governmental agencies to change laws and regulations (p. 56).

Caplan's system has not developed the role of community action from below as a major positive instrument for influencing mental health and a strategic element in prevention of emotional disorder. Indeed, relatively few mental health professionals have given much attention to the role of community action. The NSC, as a structure, and the use of nonprofessionals, as personnel, allow for the much fuller development of community action.

The mental health movement characteristically has been concerned with the integration and organization of supplies from above; hence the critique of the fragmentation of services and the stress on providing continuity and integration. Caplan is primarily concerned with supplies as the above quotation indicates. By contrast, Reiff (1964) is concerned with the development of "effective demand," and the community action section of the Economic Opportunity Act is oriented toward the development of community demand from below. It is noteworthy that the anti-poverty movement is largely concerned with the therapeutic aspects of this community development—with self-help and the like—and is less concerned with the development of community action in the direction of institutional change. This reflects the anti-poverty focus on changing people rather than institutions. The goal is more in the direction of sociotherapy rather than institutional change. While we recognize the potential value of sociotherapy, we believe that in order for action to be fully effective at a therapeutic level it must have a direction. The particular direction that we shall suggest later is institutional change of a certain type.

Caplan (1964) has noted that preventive psychiatry is fundamentally concerned with affecting rates of disorder. In this sense it is sociological in the Durkheimian tradition, not directed toward the individual. Durkheim (1952), and his followers, long ago noted that rates of pathology and other social facts could be varied as a reflection of other social phenomena. In particular, Durkheim observed that one type of pathology, namely suicide, varied inversely with the social cohesion of the group; thus, suicide rates were greater among urban groups, divorced individuals, people whose economic status had changed rapidly, and so on. More recently, Leighton (1965) has noted that more integrated communities appear to be less subject to mental stress and mental illness. Social cohesion, of course, is only one community relevant variable that might be treated, and it does not affect all types of disorder equally. In fact, there are certain types of disorder which may not be significantly affected at all by varying the cohesion of a community. It is of interest to note that suicide rates are relatively low in the Harlem community, while other forms of social pathology, e.g., drug addiction, are high. Increasing cohesion, however, should not only limit pathology but should also provide increased positive mental health, greater autonomy, independence, and the like.

Another community-relevant variable which might be effectively manipulated in a similar fashion is the involvement of the community in local issues. These can vary from clean-up campaigns to the reduction of violence or anti-drug approaches to social and political issues. Preston Wilcox in East Harlem has developed a self-help approach oriented toward some of these issues largely in a nonpolitical and nonconflict format (Sexton, 1965). On the other hand, as Riessman (1965c) has observed, Saul Alinsky has emphasized the stimulation of conflict which is to be directed toward some local enemy. Alinsky's followers have claimed marked sociotherapeutic results as well as the reduction of crime and delinquency in areas he has organized—in particular, the Woodlawn Organization (TWO) in Chicago. One of the mechanisms that may be operative here is the elimination of the little "rumbles" by making one great big "rumble"; that is, turning attention and hostility toward a common enemy outside the community. Both Haggstrom (1964) and Silberman (1964), in discussing the Alinsky approach, have emphasized the importance of social action in developing the dignity of the poor, reducing apathy, and the like.

There are a number of dangers in the sociotherapeutic approach which should be mentioned before going further. Most of its advocates generally suggest social and political goals of a liberal or progressive character, e.g., civil rights, rent strikes, campaigns against consumer fraud, and so on. It should be noted, however, that it might be possible to have highly reactionary programs which are also sociotherapeutic. Reiff[3] has argued that it is possible that the Nazi movement in Germany had sociotherapeutic effects for many of the people involved in it. Another issue which must be considered is that in any program which is mounted, the sociotherapeutic effectiveness depends upon careful planning to assure that the program has meaning and at least limited success. It is important that such programs be sustained and spread, or multiply in the community, and not be short-lived. Otherwise the gains will be short-lived, and cynicism and disappointment will set in.

We believe that an NSC program has something to learn from certain sociotherapeutic aspects of Alinsky's approach, but his focus has a number of limits from our viewpoint. For the most part, Alinsky has focused on and helped to organize the potentially militant sections of the poor who are more prone to accept the conflict position he advocates. In any neighborhood of the poor, people will come forward when grievances are stressed, and it is not difficult to stir their anger. But we suspect that these people represent the potential "actives" of the community. By contrast, there are large segments in the communities of the poor who are left untouched and unmoved by militant appeals.

Organizing the inactive poor, sometimes called the apathetic poor, is a much more difficult task than organizing the potentially militant or activist poor. It is our contention that the former can be best appealed to initially on the basis of individual service rather than militant group action. After providing some service for them, these individuals can be drawn into small groups of an informal type; initially these groups meet in the houses or buildings of the people being served. Their meetings are highly informal and primarily social in terms of the nature of the interaction. Later on, these groups meet in the NSC, which is characterized by informality and staffed by people from the neighborhood. The indigenous nonprofessionals lead meetings that are highly social in character. These groups work toward obtaining improved service for the members of the community and influencing institutional change in the service-providing agencies. This is the long-run goal; the immediate objective would be the development of various types of small groups, social groups, service groups, task-oriented groups.

The sociotherapeutic goal is the development of cohesion, involvement, and independence and the reduction of isolation, apathy, and powerlessness. The means for the achievement of this goal is the utilization of individual service, group service, and community meetings and the development of various types of leadership.

It is believed that the nature of the NSC and its nonprofessional staffing are especially appropriate for the development of this type of sociotherapeutic programming. The following outline of a community action model represents an attempt to formulate the program in relation to six phases of development, the first phase involving the recruitment and training of the nonprofessionals who are primarily responsible for the implementation of the later phases.

---

[3] Personal communication.

A New Community Action Model

This new approach to community action is proposed in order to involve segments of the poor hitherto unreached by either service programs or protest social action groups. The objective is to engage this population in a graduated series of tasks of increasing complexity, beginning with individual service and moving through five phases toward involvement in large-scale community action.

The target population is composed of segments of the poor who are most in need of services, have been least active in their own behalf, are least responsive to militant, conflict-centered appeals, and have limited experience with meetings, organized activity, and formal leadership.

Our assumption is that previous social action approaches have failed because they have not started where the poor are. The programs were not begun in relation to the service needs of the population concerned. On the other hand, service-oriented approaches have also typically failed with this population because of a lack of direction and development; that is, the approaches were largely oriented toward providing individual services for the people involved but were not aimed at moving them toward group activity, stages of community action, and leadership development. In other words, there has been a bifurcation of service and social action approaches. This is most evident in the programming of Mobilization for Youth, where the Community Organization and the Neighborhood Service Center approaches were, in the main, separated from each other. We believe that the form of service-based social action to be outlined is most appropriate for government-supported projects, since it is likely to produce the least political backlash of any type of social action.

The proposed program is based on an attempted integration of projects and concepts such as Mobilization for Youth's Parent Education Program developed by Dowery as distinguished from its other more militant community organization programs (Riessman, 1964), the self-help concepts formulated in particular by Preston Wilcox (Sexton, 1965), applications of small group theory and technology to social change, as enunciated by Peck, Kaplan, and Roman (1965), and the utilization of the style and know-how of indigenous personnel (Brager, 1965). The approach is in sharp contrast with the community mobilization, protest social action approaches of Alinsky and Mobilization for Youth. The model is outlined in a six-phase plan as listed below for an NSC program functioning in a mental health context.

Phase One: Recruitment and Training of Nonprofessional Mental Health Aides. The nonprofessional mental health aides are such a fundamental part of the functioning of the NSC program that it may be useful to survey briefly some aspects of the recruitment, selection, and training of the group. The initial recruiting was done largely through the formal and informal agencies of the community, local radio stations, community meetings, the state employment services, JOIN, and so on. We indicated that we were looking for people who lived in the neighborhood and would like to work with people and that we did not require completion of a high school education. Forty-five people applied for the positions, and six of these were ultimately selected for the initial training program. The selection procedure was as follows:

1. A large meeting of all the applicants was held at which we described the job, indicated personnel practices, salary, and so on, and answered questions.
2. The next phase consisted of group interviews in which the total group was broken down into groups of ten or eleven individuals. These interviews were held in a room which had a one-way screen behind which sat four judges: a psychologist, a social worker, a psychiatrist, and a nurse. The group interview was conducted by two people and was directed toward ascertaining the candidates' attitudes toward the neighborhood—whether or not they rejected the people who lived in the neighborhood; attitudes toward people on welfare; feelings about discrimination, minority groups, disturbed people, and so on. The judges observed the group process and rated the applicants with regard to the following characteristics: empathy, attitude toward authority, comfort in a group, ability to communicate ideas and feelings, trainability and flexibility, capacity for self-awareness, reaction to stress, pathology, and relevant work and life experience.

We were particularly concerned that the people we selected be "bridge" people; that is, be able to communicate with ourselves, with the professionals, and with the people in the neighborhood.

3. From the four original groups, a further group was selected for another group session.
4. An individual interview was held for candidates about whom there was still doubt.

The training program was divided into three phrases:

1. A pre-job period of three weeks in which the training was based at the Lincoln Hospital Mental Health Clinic. The emphasis was on operational tasks such as community surveys, door-to-door interviews with families, assisting the intake team at the hospital, visits to various agencies such as the Department of Welfare, the Police Department, the schools and so on. Job stimulation and role playing

were central features of the training in this phase, and there was very little didactic presentation. The training was conducted by the NSC staff, including two psychologists and three social workers. All had considerable experience in training, and three of them had specific experience in the training of nonprofessionals.

2. Following the three-week intensive training program, the aides were placed at the NSC for a period of two weeks; half of their time was devoted to specific service to residents of the area and the other half was spent in further training based now on the on-the-job experiences. Thus, the center was open for one-half of the day, and the aides actually functioned fully in this period of time.
3. Ongoing training takes place continuously at the center which is now open and in full operation. Approximately one-fifth of the week is spent on systematic training—the development of new skills, further understanding of and identifying of mentally ill people. Once a week the aides participate in a group meeting with the training coordinator to discuss their on-the-job problems and to help develop general principles and learn additional helper techniques. On-the-job supervision is supplied by the director of the NSC. In addition to regularly scheduled conferences, the aides have the opportunity to use the supervisor on an as-needed basis.

Phase Two: Basic Individual Services. In this phase, the indigenous nonprofessional workers have as their focus discovering the needs of the community and informing the community of the presence of the NSC. Major tasks of the center itself relate to the expediting of service and to the provision of simple services such as filling out forms, writing letters, escorting people, translating, etc. A fuller discussion of the expediting function is provided by Reiff and Riessman (1965).

The training needs in this phase relate to the acquisition of information about community resources, about knowing channels and how to cut through red tape, about stimulating clients to follow through. Basic interviewing skills have to be learned. The role model of friendly neighbor has to be enlarged upon to enable the workers to provide the listening ear and emotional support necessary for psychosocial first aid.

Phase Three: Small Informal Groups. The emphasis in this phase is on the development of small group activity, initially home-based, in preparation for the community meeting involving all the people who have received service at the NSC. Each month, all the people who have visited the center for service are invited to a community meeting at the center conducted by the mental health aides. The meeting is oriented toward discovering the needs of the neighborhood, organizing groups or committees to deal with these problems, and developing leadership.

The training needs at this stage relate to the development of groups, home visits and follow-up, the spotting of leaders, the deepening of counseling approaches, and further psychological understanding.

Phase Four: The Community Meeting and Task-Oriented Groups. The emphasis in this phase is directed toward the development of various types of more organized group activity. The functions of the nonprofessional involve organizing the community meeting—informal, social dimensions and task-oriented aspects; starting service groups and task-oriented groups; developing campaigns, particularly in relation to under-utilized health services, the use of surplus foods, and registration of children in preschool programs.

The training needs at this stage relate to providing skills for developing committees, preparing people to participate in other organizations, e.g., PTA meetings, and planning campaigns.

Phase Five: Intergroup Programs. The emphasis in this phase is on relating the committees and groups developed at the NSC to other groups and forces in the community. Leadership development, an extremely important phase of the program, is facilitated through combining with other agencies, planning councils, and community groups on a larger community action basis; planning community action in relation to services which are not under-utilized and where there may be some political backlash (e.g., welfare, schools, etc.); formal leadership training development, knowledge of service-giving techniques, participation on advisory committees, special counseling, and clinical assistance where necessary.

Training needs here relate to community action skills, the development of "meeting" tactics at a higher level, leadership training techniques, and methods of "teaching" low-income people.

Phase Six: Institutional Change. This final phase, to be elaborated on more fully in the next major section of the chapter, is concerned with coordinating community action programs throughout the city and country. The "open conspiracy openly arrived at" calls for bringing together representatives of community action projects from diverse places who have problems in common, the solution of which requires the development of programs in relation to employment, welfare, and housing on a national scale. This is a long-run objective.

Institutional Change

In order for the sociotherapeutic effects of community action to be other than temporary, the program must have achievable objectives; and some of these objectives must, in fact, be achieved in a reasonable period of time. School boycotts that do not produce changes in the schools can have sociotherapeutic effects of only short duration. Moreover, the disillusion that sets in from repeated failure may have consequences that far outweigh the short-lived sociotherapeutic effects.

It is not difficult to establish and achieve certain short-run aims: underutilized services such as prenatal care can be better utilized through organized group-oriented campaigns; self-help projects directed toward clean-up campaigns, renovating vacant lots, etc. are eminently achievable. There is no question that "the system" has considerable "give" in it, and it is the responsibility of community action programs to assess this "give" and maximize it.

But there comes a point where in order for the community action program to have continued momentum, larger, more fundamental changes are necessary. The question arises as to which of these changes falls within the province of a mental health oriented agency supported by public funds. We believe that it is appropriate for an NSC program to seek institutional changes in public and private agencies that will enable them to provide improved, integrated service. A widely held mental health aim today is directed toward more continuous, coordinated, comprehensive service. Hence, changes in policies, practices, and structure in relation to the service-providing agencies would seem to be an appropriate aim. This objective is consistent with the overall mental health orientation of the Lincoln Hospital Mental Health Services and seems necessary if the war against poverty is to have any large meaning.

However, the goal of institutional change is less intrinsically related to the structure and character of the NSC program than is the direct service goal or the development of community action. The center is, by its very nature, related to the development of demand by the people in their own locale. It is less immediately related to the formal agencies of the community. Of course, it is necessary to relate to these agencies in order to expedite service, but this requires a reaching out by the NSC. Its more natural function relates to the people in the area, not to the institutions. Even when it reaches out to the institutions, this is by way of expediting service rather than institutional change. Providing service and developing community action are, thus, seen as objectives that are more intrinsic to the NSC, while institutional change is somewhat more extrinsic and, to some extent, appended. Nevertheless, for the reasons cited above, we feel that it is a necessary aim if we are to develop service to new levels and provide a meaningful long-run objective for the community action program. To be fully effective, the NSC orientation toward institutional change should probably be placed in the context of the larger parent group, in this case the Lincoln Hospital Mental Health Services and its network of influence. The strategy and technology of the parent group is more definitely directed toward institutional change (Peck et al., 1965).

There are, however, a number of dimensions of the NSC itself which bring it into the arena of institutional change, at least indirectly. First, its very existence upsets the equilibrium of the agency system. By its very nature it makes new demands with regard to the distribution and organization of services by the other agencies in the community. Its mandate from the Office of Economic Opportunity provides a legitimacy for its service demand and role in the community. Moreover, it does not simply treat its "customers" as consumers of service, but organizes them as group members, citizens, demanders of service. Its community action dimension provides a powerful lever for institutional change.

It cannot be emphasized enough that the present anti-poverty climate provides further implicit power for the NSC. The center's mandate seems to require the improvement of services, and it has certain sources of power for implementing the betterment of these services. For example, it has fairly easy access to publicity and thus can play a type of watchdog role, making known its complaints about the inadequacy of service to the poor.

Moreover, the stance of the NSC program represents something of a third force, suggesting that it is an intercessor or mediator between the people and the agency decision makers. The NSC does, in fact, stand midway between these two forces, much nearer to the neighborhood people than any other agency, and nearer to the agencies than any other community organized group. While it has special power deriving from this position, there are attendant limitations. A protest social action group, which lies further away from the agencies, has force that the NSC does not possess. On the other hand, the social action group does not have the mediation potential of the NSC. The NSC can also affect institutions in the community via an imitation or contagion effect. We have observed that a variety of group-serving agencies in the area have requested guidance in establishing smaller NSC programs.

There are many paths by which institutional change can be introduced into the community by means of the NSC program. The power of the NSC to provide assistance to other agencies in the community, via the service and expediting it provides, can serve to influence, reciprocally, the responses and rules of these agencies. Thus, the Welfare Department might be persuaded to provide for consolidated caseloads with a welfare worker based in one NSC and serving the center's area. A similar development could be achieved with other agencies, such as housing. JOIN—Jobs in the Neighborhood—established such a relationship with the first NSC.

To the extent that the NSC program utilizes a legal approach, such as that developed at Mobilization for Youth, it has the possibility of fostering institutional change through the use of the law. Mobilization for Youth is attempting to make significant changes in Department of Welfare practices by taking specific cases to court. It should be noted that the legal approach does not require an NSC. It is neither a natural outgrowth nor a necessary development of the NSC program. Nevertheless, it may be extremely useful as an added feature.

Insofar as the NSC, in its community action role, develops leaders in the community, it indirectly produces a force related to institutional change.

Finally, it should be noted that the NSC itself might become a permanent new institution in the community. It can and should perpetuate itself as a new force in the service development of the community. By so doing, all the practices and policies that it develops become part of the institutional fabric of the area.

Any program such as we have described must plan for the continued development and motion of people. Plans must be developed not only for the high periods of excitement and intense activity but also for the low periods in which there is an ebb in motivation and concrete action. New activities must be planned for different stages—in the early phases, the small groups and social types of activity which are more informal in character; later, the service groups, the task-oriented groups, the community meetings, the campaigns, etc. It is only through this type of planning that the involvement of the poor can be developed and maintained. These plans must also include the recognition that many people will not move along through all the various phases and that these people must not be lost. The community's development is uneven, and we cannot demand that everyone become involved in intense campaigns. People must have the possibility of maintaining their involvement and attachment to the groups that are formed, and various roles must be developed that they can fulfill other than through their becoming leaders.

The impact of institutional change on mental health is somewhat more indirect than the sociotherapeutic effects of community action or the stress-reducing effects of added or improved service. Intervention at the "top" takes time to develop; and its effects on mental health, while perhaps more pervasive, are more delayed than is direct functioning in groups aimed toward greater cohesion. The latter probably has more immediate mental health-producing properties. It is important, however, that community action not simply endeavor to be a therapeutic process in and of itself, but actually achieve some changes in the system that have long-run mental health consequences.

OTHER NSC GOALS: SECONDARY AND TERTIARY PREVENTION

There are various possible models for the mental health-oriented NSC. One way of viewing the possibilities relates to whether the center is to be concerned mainly with primary prevention, secondary prevention, or tertiary prevention. The model described above is principally concerned with primary prevention. The tasks of the aides are related to this goal, as is their recruitment, selection, and training. The NSC oriented toward secondary prevention and tertiary prevention would develop very different programs and correlatively would have different recruitment, selection, and training procedures.

Secondary prevention-focused centers, since they would be concerned with early case finding and rapid referral, would have to train the mental health aides much more fully to detect the signs of pathology, to persuade clients to utilize clinical facilities, and to serve in holding actions or other interventions where these facilities were not available. Twenty-four hour emergency service at such an NSC might be indispensable in order to catch people at the point of crisis and provide immediate assistance, both of the first-aid type as well as the clinical referral that would be expedited and followed up by the aides. There is the possibility that the referral sources in the community may be limited, and therefore a secondary prevention-oriented program might uncover more cases than could be adequately treated by the existing clinical facilities. Under these circumstances, a secondary prevention program might consider adding to the treatment technology or intervention skills of the mental health aides themselves. Here the aides would not merely provide psychosocial first aid but would expand their skills and move toward various types of counseling, group approaches, etc. The aides might be trained in how to coordinate with mental health specialists, who would appear at the NSC weekly to conduct specialized diagnostic work, prescribe drugs, and so on. In addition, the aides might be trained as group therapy assistants, thereby expanding the efficiency of professional personnel. In this model, the NSC begins to approach a neighborhood mental health clinic.

While it is possible to develop an NSC orientation which focuses on finding the ill members of the community and institutes some intervention as rapidly as possible, there are some special issues that have to be confronted in doing this. First, if the NSC becomes known as a clinic for emotional problems, there is the possibility that the neighborhood will focus more on these problems; people to some extent may develop the appropriate symptomatology in order to receive service, and the community action orientation may be reduced. Community people and social agencies alike may find and refer far more people with emotional problems. It is interesting to note that as the first NSC becomes known for its mental health aides and mental health back-up orientation, social agencies in this community increasingly refer more and more people with psychological problems. As yet, this form of referral has not taken place from among the population of the area itself. In other words it is the external caretakers, not the internal ones, who are referring clinical cases so far.

It is noteworthy that in the early days of the operation of the Benjamin Rush Clinic in Los Angeles, hundreds of low-income people waited in long lines to receive crisis-oriented, short-term therapy after the newspapers had announced that such treatment was available at low cost. The question remains whether it is useful to a community to select this emphasis and appeal.

It might be argued that large numbers of people in the low-income community have ego defects and therefore have need for therapeutic intervention. In this formulation, secondary prevention is carried considerably beyond the public health model espoused by Caplan (1964). Caplan is mainly concerned with case finding, rapid referral, and treatment of actual disorders; he wishes to reduce the prevalence of mental illness, not underlying pathology, and he aims to do this by reducing the length and intensity of the disorder by means of early detection.

There is no necessary reason, of course, why clinically oriented treatment as well as other forms of intervention (environmental manipulation, involvement in social groups, etc.) cannot be made available for people with emotional disturbance at the same time that other problems—health, housing, and the like—are dealt with and perhaps even emphasized at the NSC.

The question remains whether the treatment technology to be provided through an NSC program for the psychologically disturbed should consist of counseling, group therapy, and the like, or whether the emphasis should be more on social forms of intervention—involvement of people in various types of groups, etc. If the latter is the case, the training of the aides and the program of the center would be of a different character. In this model, although the aim would be the reduction of pathology, the methodology would not be clinical. It is clear, of course, that for different kinds of pathology, different intervention patterns would be necessary. We are not suggesting that sociotherapeutic methods can be equally effective with all types of illness. What is less clear, however, is whether the NSC is an appropriate place for the extended utilization of technologies other than sociotherapeutic ones.

A related issue that arises is whether it is possible to train mental health aides in a wide range of skills—whether they can, in fact, be generalists. Is it likely that the same nonprofessional can develop community action skills and clinical skills, or is it more appropriate to think of different aides developing different repertoires depending on their personalities, previous backgrounds, and the training that is introduced to develop these latent abilities? Moreover, the approach to nonprofessionals which emphasizes the development of their style, neighborhood "know-how," basic approach to people—their "subjectivity"—and peership would seem to be less relevant in terms of development of specific therapeutic skills. From the viewpoint of counteracting the mental health manpower shortage, it may be useful to develop nonprofessionals as group therapy assistants and the like, but it does not particularly take advantage of the nonprofessional's neighborhood base, history, and background.

In the tertiary prevention model, the NSC could serve as a rehabilitation base for aftercare groups, keep-in-touch clubs, etc. Social groups of various kinds could meet at the center with the aides playing an important role in working with these groups, always supervised and perhaps assisted by judicious, periodic use of professional personnel—personnel that need not necessarily be stationed at the center. The aides might serve a strategic role helping the returning patient to relate to his family and the community. Home visits could be made to the patients' families to help them prepare for the returnees. The mental health aides could also work with the patient upon his return and assist him in becoming involved in the community. We believe that it would be uneconomical for an NSC program to devote itself entirely to tertiary prevention, although it can serve a significant ancillary function.

There is more likely to be a melding of NSC approaches whereby some of the internal caretakers or care-givers of the community, as well as the be utilized in an aftercare program for the rehabilitation of people returning to the community from mental institutions. Thus, a sewing group which might have specific value for a number of people living in the area might also be suited for returnees. Here, the program is planned in relation to primary prevention and serves in an adjunctive fashion as a rehabilitation resource.

In both the secondary and tertiary prevention models, the involvement of the internal caretakers or care-givers of the community, as well as the various therapeutic self-help groups, might be an important feature. Alcoholics Anonymous and other similar groups could be developed in the community, conceivably based at the center; or the center could be used as a major meeting place for these groups. In this sense, treatment and prevention are closely allied.

CONCLUSION

The Neighborhood Service Center (NSC) is an innovative structure directed toward providing a more effective approach to low-income disadvantaged people. The present program is a product of the cross-fertilization of two distinct orientations: a *preventive* approach to mental health problems and *community action*. Its three unique features include staffing by indigenous nonprofessionals, its underlying mental health orientation, and the uniting of service and community action in a carefully phased sequence.

The program has three prime goals: to expedite and to integrate services; to develop a community action program directed toward increased social cohesion within a specific area—in this case the five-block area served by the center; and to effect certain institutional changes of a limited type in relation to the service-providing agencies of the community.

An important feature of the program is its low cost. The total salaries of the five nonprofessionals working in one Neighborhood Service Center are equal to or less than the salary of one full-time psychiatrist. The operating expenses of one Neighborhood Service Center, including the professional director, the secretary (who is indigenous to the neighborhood), the five mental health aides, the rent for the store, and all other expenses, total less than $50,000 per year.

While the NSC model presented here is mainly focused on primary prevention efforts, some consideration has been given to alternative NSC models which emphasize secondary and tertiary prevention. The recruitment, training, and functions of center workers would vary considerably under the latter two orientations. The NSC approach is viewed as a viable and necessary approach to the mental health problems of the poor.

REFERENCES

Brager, G. The indigenous worker: A new approach for the social work technician. *Social Work*, 1965, *10*, 33-40.

Caplan, G. *Principles of preventive psychiatry*. New York: Basic Books, 1964.

Durkheim, E. *Suicide*. New York: Free Press, 1952.

Haggstrom, W. The power of the poor. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor*. New York: Free Press, 1964. Pp. 205-226.

Hollingshead, A. B., & Redlich, F. C. *Social class and mental illness*. New York: Wiley, 1958.

Jahoda, M. *Current concepts of positive mental health*. New York: Basic Books, 1958.

Langner, T. S., & Michael, S. T. *Life stress and mental health*. New York: Free Press, 1963.

Leighton, A. H. Poverty and social change. *Sci. Amer.*, 1965, *212*, 21-27.

Peck, H. B., Kaplan, S. R., & Roman, M. An approach to the study of the small group in a psychiatric day hospital. *Int. J. group Psychother.*, 1965, *15*, 207-219.

Peck, H. B., Kaplan, S. R., & Roman, M. Prevention treatment and social action: A strategy of intervention in a disadvantaged urban area. *Amer. J. Orthopsychiat.*, 1966, *36*, 57-69.

Reiff, R. *Social psychological action research for change*. New York: Low Income Center, Albert Einstein College of Medicine, 1964.

Reiff, R., & Riessman, F. The indigenous nonprofessional. *Comm. Ment. Health J.*, 1965, Monograph No. 1.

Riessman, F. The revolution in social work: The new nonprofessional. *Transaction*, 1964, 2, 12-17.

Riessman, F. The "helper" therapy principle. *Social Work*, 1965, *10*, 27-32. (a)

Riessman, F. Mobilizing the poor. *Commonweal.*, 1965, 82, 285-289. (b)

Riessman, F. Self-help among the poor. *Transaction*, 1965, 2, 32-36. (c)

Sexton, P. *Spanish Harlem*. New York: Harper & Row, 1965.

Silberman, C. Up from apathy: The Woodlawn experiment. *Commentary*, 1964, 37, 51-58.

11

PSYCHOLOGICAL CARE FOR THE POOR: THE NEED FOR NEW SERVICE PATTERNS WITH A PROPOSAL FOR MEETING THIS NEED[1]

Elmer A. Gardner

Temple University[2]

INTRODUCTION

The age of poverty is borne out in the history of man. Yet we have suddenly entered an age of growing concern about the poor (Harrington, 1962; May, 1964; Schorr, 1963). Poverty, together with all of its socioeconomic implications, has become the concern of science as well as of government, as witnessed in the rapid development of the behavioral sciences. Social scientists in general, and psychiatrists in particular, are becoming increasingly alarmed by the magnitude and complexity of the mental health problems which this group poses, particularly in the heart of our urban centers. Several studies (Auld & Myers, 1954; Hollingshead & Redlich, 1958; Hunt, 1960; Imber, Nash, & Stone, 1955; Myers & Schaffer, 1954; Winder & Hersko, 1955) have served to point out discrepancies in psychiatric service to different segments of the population and the ineffectiveness of classical models and methods to cope adequately with certain problems. Most strikingly inadequate is the psychiatric care provided to the poor. McMahon (1964) summarizes the problem very well in his statement, "The lower one finds himself on the social class ladder, the more unavailable does effective psychiatric care become" (p. 284).

In their classical study, Faris and Dunham (1939) found a decrease of psychiatric hospital admission rates for schizophrenia and personality disorders as one proceeded from the center of the city outward. Because of methodological difficulties it is not possible to relate community-wide surveys of mental disorder directly to the studies of psychiatric service. Studies such as the Midtown project (Srole, Langner, Michael, Opler, & Rennie, 1962) indicate, however, that the prevalence of mental disorder is higher in the lower-income groups and that the distribution of admission rates does not indicate merely increased utilization of services by this group. Hollingshead and Redlich (1958), in their well-known study, further demonstrated that both prevalence of treated mental illness and the type of psychiatric care received are directly related to social class variables. It should be noted that there are those who dispute the findings of higher rates of mental disorder in the lower social classes and contend that these rates are biased by our definition of mental disorder and by the middle-class orientation of the investigators (Davis, 1938; Gursslin, Hunt, & Roach, 1964). Studies also have noted that economic factors are not solely responsible for ineffective care to the lower classes; clinics, mainly designed to care for these groups, have failed in their ventures (Brill & Storrow, 1960; Schaffer & Myers, 1954).

---

[1] I wish to thank Mary Lynch for her valuable assistance in drafting and editing this chapter. Elise Remmeli, computer programmer, and Carol Huff, statistical clerk, compiled the data and prepared the graphs for this paper.

[2] Formerly, Associate Professor and Director, Division of Preventive Psychiatry, Department of Psychiatry, University of Rochester School of Medicine and Dentistry, Rochester, New York.

Many people working in the fields of human behavior have become aware not only of our lack of knowledge in many areas but of our hesitation or inability to put to efficient use that knowledge which we already possess (Brill & Storrow, 1960; Hollingshead & Redlich, 1958; Myers & Schaffer, 1954). The following presentation of data from the psychiatric case register of Monroe County, New York, describes a longitudinal view of the psychiatric services provided to patients from upper and lower socioeconomic areas of the county, with particular reference to a comparison of rates of diagnosed mental disorder in those areas.[3] We will then present an attempt to bridge the gap between such knowledge and its application in a description of a project organized to provide psychiatrically guided services to population segments which need, but often do not now receive, adequate psychosocial help. In addition, we will discuss some of the difficulties encountered when working within the framework of present community organization. Finally, we will discuss our own views of a holistic approach to this problem.

THE REGISTER STUDY

A case register of the psychiatric services provided to the residents of Monroe County, New York, was initiated in January, 1960. A comprehensive description of the goals and the operation of the register has been presented elsewhere (Gardner, Miles, Bahn, & Romano, 1963; Gardner, Miles, Iker, & Romano, 1963). Essential demographic, diagnostic, and treatment information is reported to this central file upon initiation of service by any of the following facilities, which comprise an almost complete range of traditional psychiatric service: a state hospital and its outpatient services; the inpatient, clinic, and emergency department services of a university hospital; an acute observation unit; a Veterans Administration hospital and clinic; a children's residential treatment center; an alcoholism clinic; two child guidance clinics; and about fifty-five psychiatrists who spend varying portions of their time in private practice. Since January, 1960, all but an estimated 3% of the county residents seen for psychiatric care have been reported to the register.

---

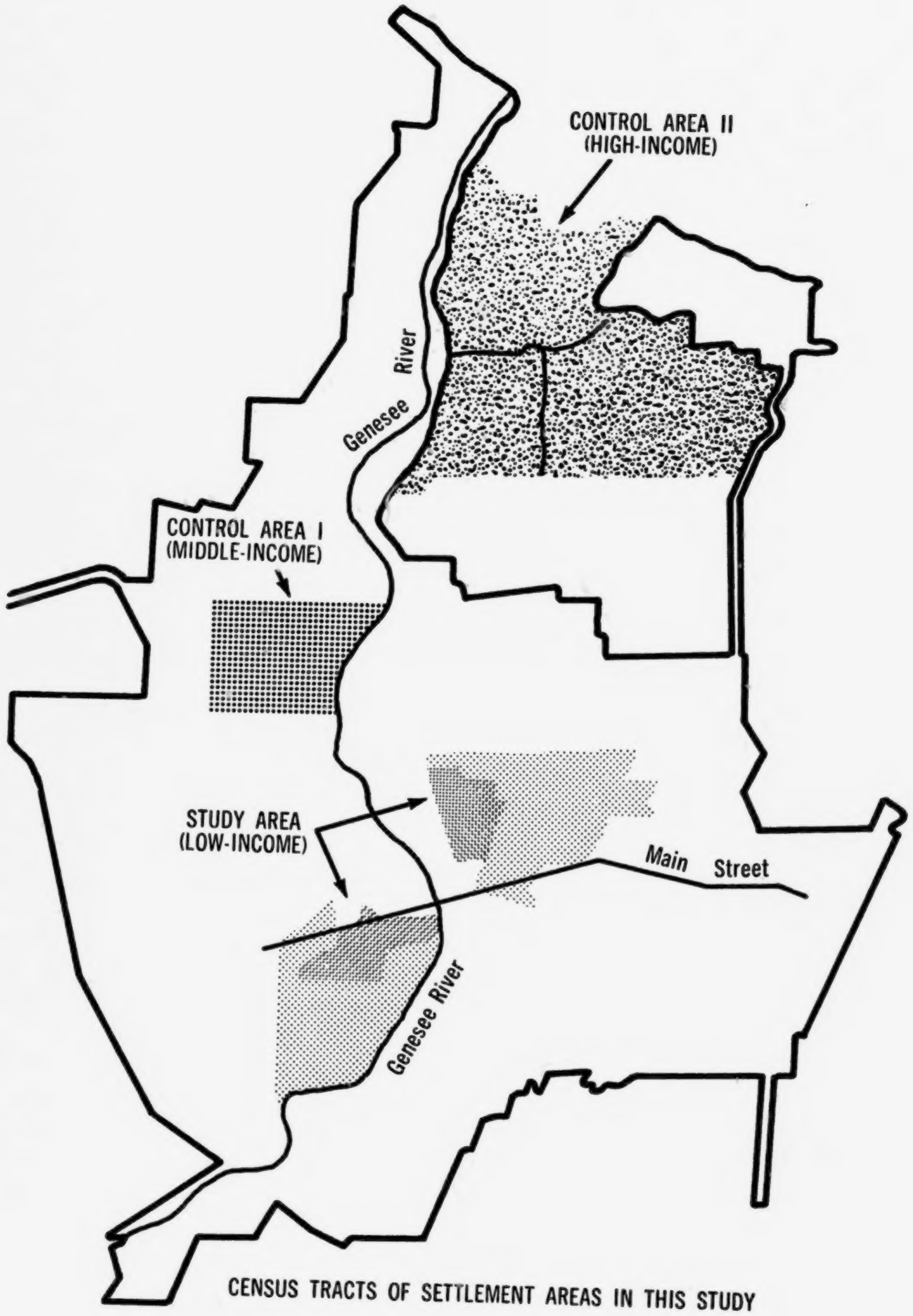
[3] Figures 1, 2, 3, 4, 5 are from the comparative study of psychiatric services for low-, middle-, and high-income areas in Monroe County, New York.

In utilizing the case register to study the usual service pattern for residents of the inner city, we first selected all patients with or without a history of psychiatric care prior to January, 1960, who were reported between January 1, 1960, and December 31, 1962. In our subsequent discussion we shall be referring to *diagnosed* mental disorder and not all mental disorder within any particular population. Because a person may have more than one episode of psychiatric service[4] and because he may receive more than one diagnostic impression for each episode, we utilized a priority system in assigning an individual to one of three broad diagnostic categories. First priority was given to the diagnosis of schizophrenia, second priority to chronic brain syndrome, and last priority to any other category. We have included the diagnoses of affective psychoses within the broad category of "others" due to the insignificant rates of these diagnoses for the inner city tracts, particularly among the Negro population.

The address for each individual is assigned to a census tract, and priority was given to the inner city tracts in instances of multiple addresses during a succession of psychiatric contacts. We first selected the census tracts which comprised four out of five settlement house districts within the city of Rochester, New York. The fifth district, which differed considerably from the others, was included with the remainder of the city. It soon became apparent, however, that these four settlement areas contained a socially heterogeneous population; using selected socioeconomic and demographic characteristics, five census tracts from within these four settlement areas were selected in an attempt to provide a more homogeneous population. These five tracts will be referred to as the study area. For comparative purposes, two other areas were selected and designated as control area I and control area II. The location of the settlement districts and the smaller groupings of census tracts selected for study are shown in Figure 1, while Figures 2 and 3 depict some pertinent socioeconomic and demographic characteristics of the selected areas.

---

[4] The terms *episode of service* and *contact* will be used synonymously throughout the paper. They refer to any one complete continuous period of psychiatric service in a hospital unit, a clinic, or with one psychiatrist in private office care. These terms may refer, therefore, to one or more outpatient visits.


CONTROL AREA II
(HIGH-INCOME)
Genesee River
CONTROL AREA I
(MIDDLE-INCOME)
STUDY AREA
(LOW-INCOME)
Main Street
Genesee River

CENSUS TRACTS OF SETTLEMENT AREAS IN THIS STUDY

Baden Street Settlement	— 11, 12, 13, 14, half of 15
Genesee Street Settlement	— 43, 53, 55, 56, half of 15
Lewis Street Center	— 44, 45, 09
Montgomery Neighborhood Center	— 3, 4, 26, 27, 64, 65, 66, 67

Figure 1. Geographic Location of Study and Control Areas in the City of Rochester, New York, and Vicinity.

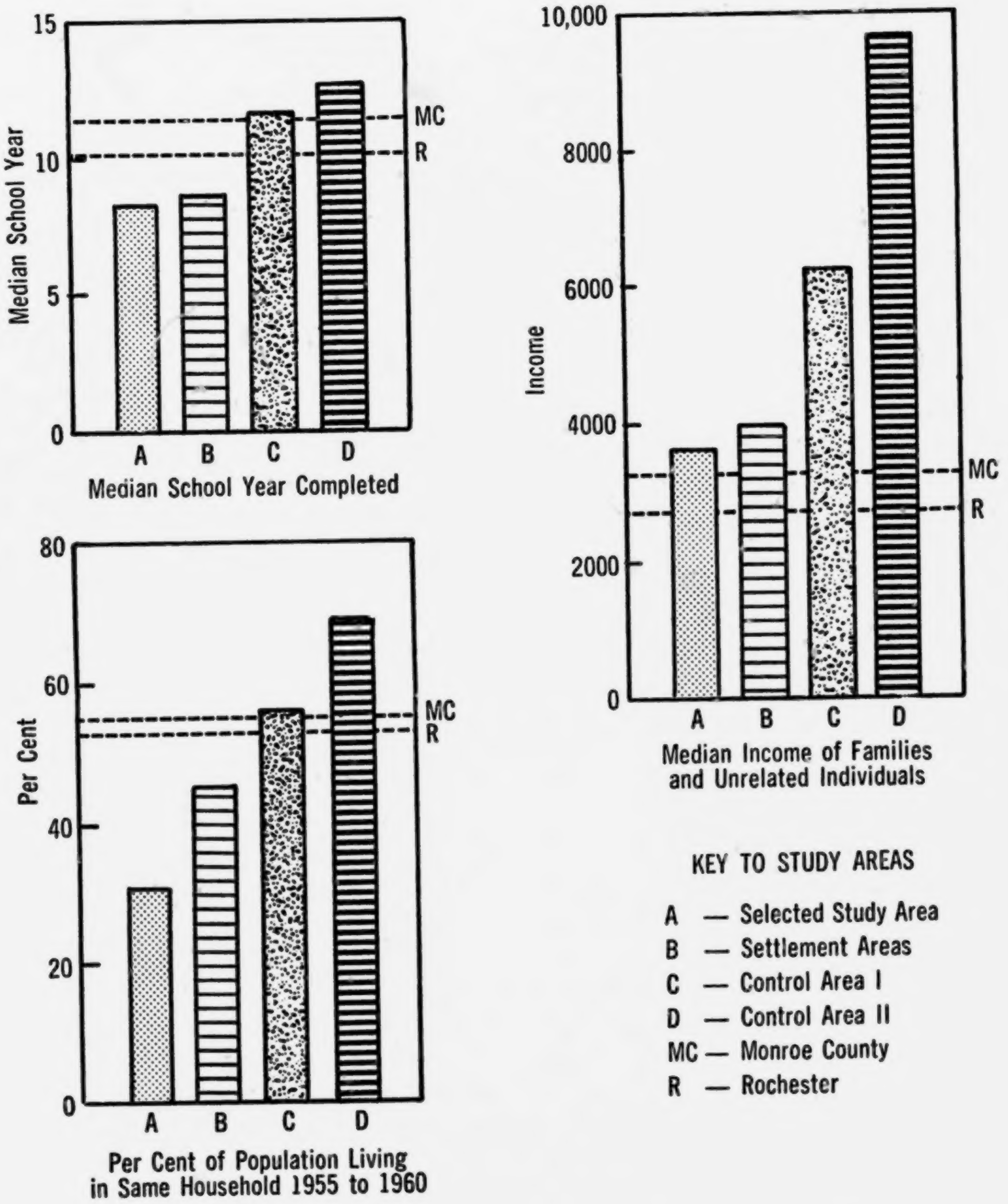


Figure 2. Selected Socioeconomic and Demographic Characteristics from 1960 Census for Study Areas, Monroe County, New York.

Table 1 presents the population distribution by area and race based on 1960 census data. As noted from the selected socioeconomic and demographic characteristics in Figures 2 and 3, the study area represented a low-income deteriorated area with a two-thirds nonwhite population; control area I and control area II are characterized by average and high-income levels, respec-

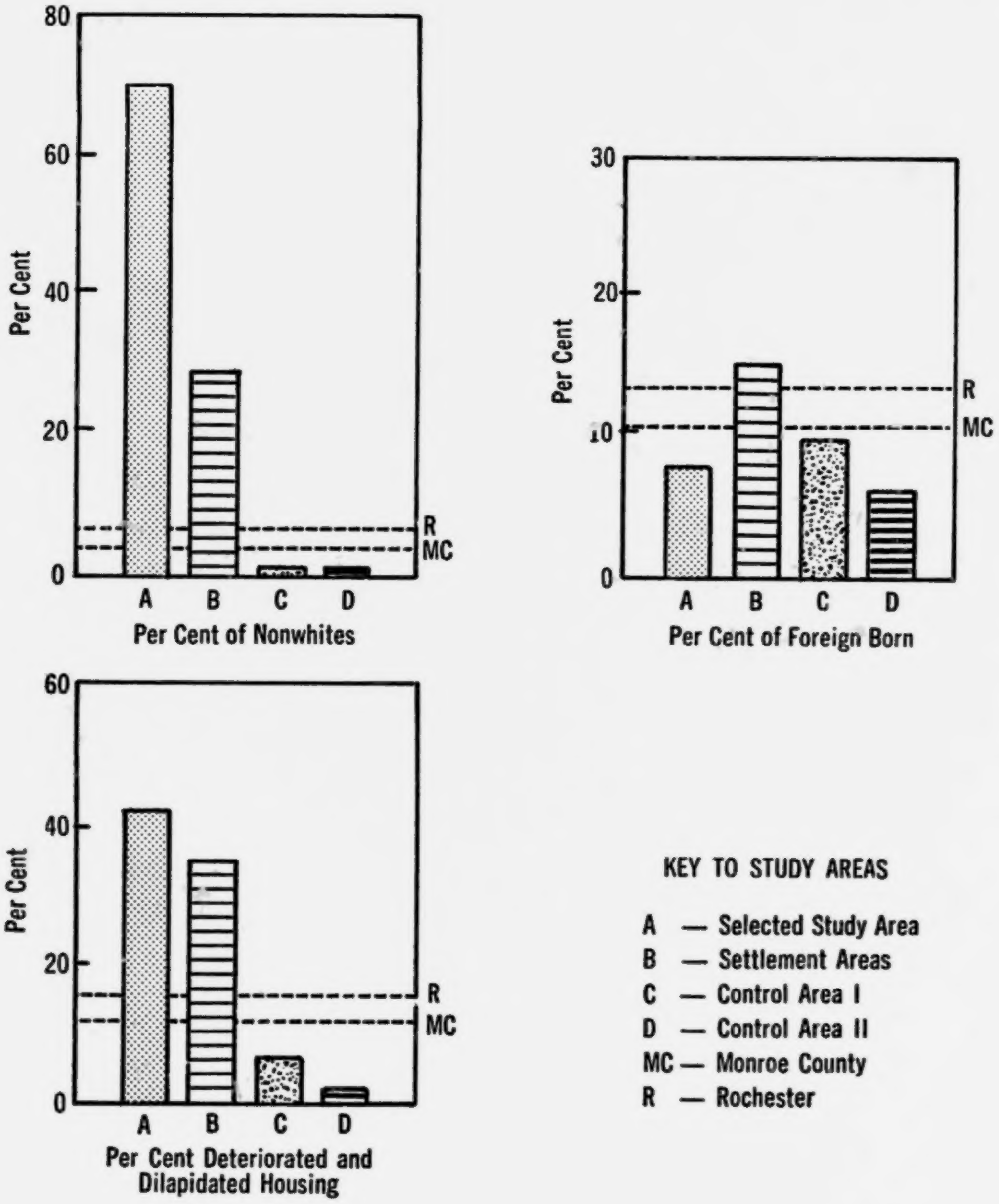


Figure 3. Selected Socioeconomic and Demographic Characteristics from 1960 Census for Study Areas, Monroe County, New York.

tively. Thus, the settlement districts and the three selected areas range from the low to high points along socioeconomic and demographic parameters. The 1960 census data and our own direct observations of the areas have shown that the study area and the two control areas, respectively, each provided a fairly homogeneous population sample.

Table 1. Comparative Study of Psychiatric Services for Low-, Middle-, and High-Income Areas in Monroe County, New York

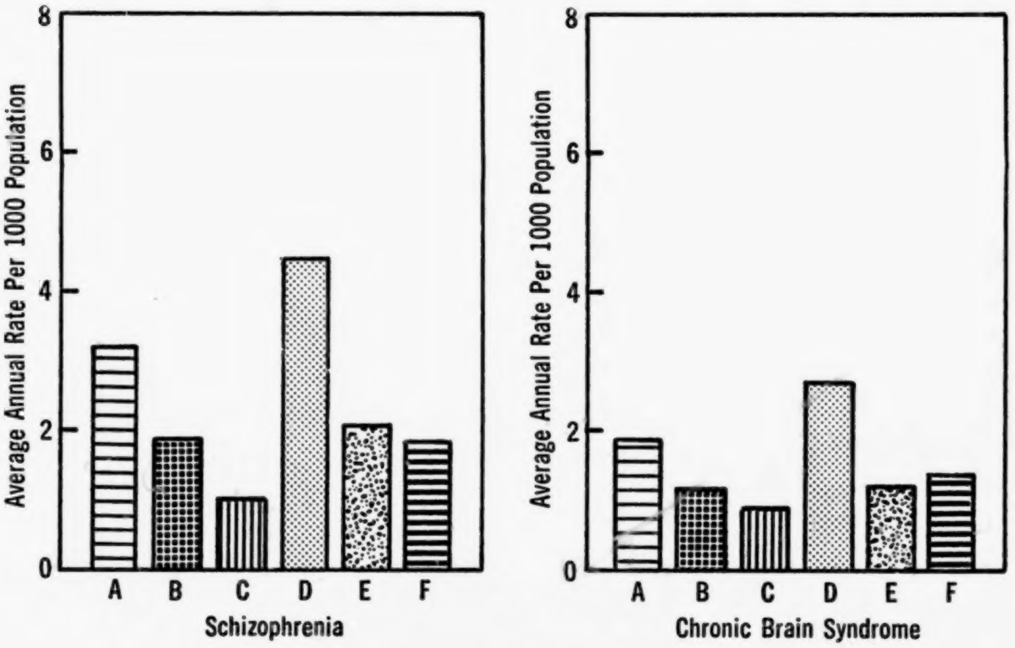
		Per Cent Distribution By Race	
AREAS OF STUDY	POPULATION	% NON-WHITE	% WHITE
MONROE COUNTY, TOTAL	586,387	4.3	95.7
Rochester	318,611	7.6	92.4
Balance of County	267,776	0.3	99.7
Settlement Areas	64,252	32.2	67.8
Selected "Study Area" (Low-Income)	13,751	69.0	31.0
Control Area I (Middle-Income)	15,019	0.01	99.99
Control Area II (High-Income)	14,005	0.1	99.9

PSYCHIATRIC SERVICE: CROSS-SECTIONAL PATTERNS

Figures 4 and 5 compare the rates by broad diagnostic groupings for all persons admitted to psychiatric service during the years 1960-1962. As noted in other studies, the rates[5] of diagnosed mental disorder are greatest for the inner city and become progressively lower as we proceed toward the outlying areas. This differential becomes even more striking when one selects the most homogeneous tracts within the inner city and compares them with the two groups of peripheral tracts. The contrast between the study area and the two control areas is most marked in the rates for schizophrenics and alcoholics. Thus, in our study of total psychiatric service, both inpatient and outpatient, we find a distribution comparable to that noted by Faris and Dunham (1939) in their study of hospital admissions.

During the three-year period, 14,067 persons (or 2.3% of the county population) were reported to the case register. Of these, 2,406 individuals came from the settlement areas. Although the latter comprise only 8.9% of the county population, they account for 17% of all county residents receiving psychiatric service and 21% of those persons diagnosed as schizophrenic. If we exclude the population under age ten, where the rates for psychiatric care are extremely low in Monroe County, we find that slightly more than 6% of the adult settlement area population had a psychiatric contact during this three-year period.

[5] These rates and all other rates presented in the figures or tables are age adjusted to the 1960 United States population.



KEY TO STUDY AREAS

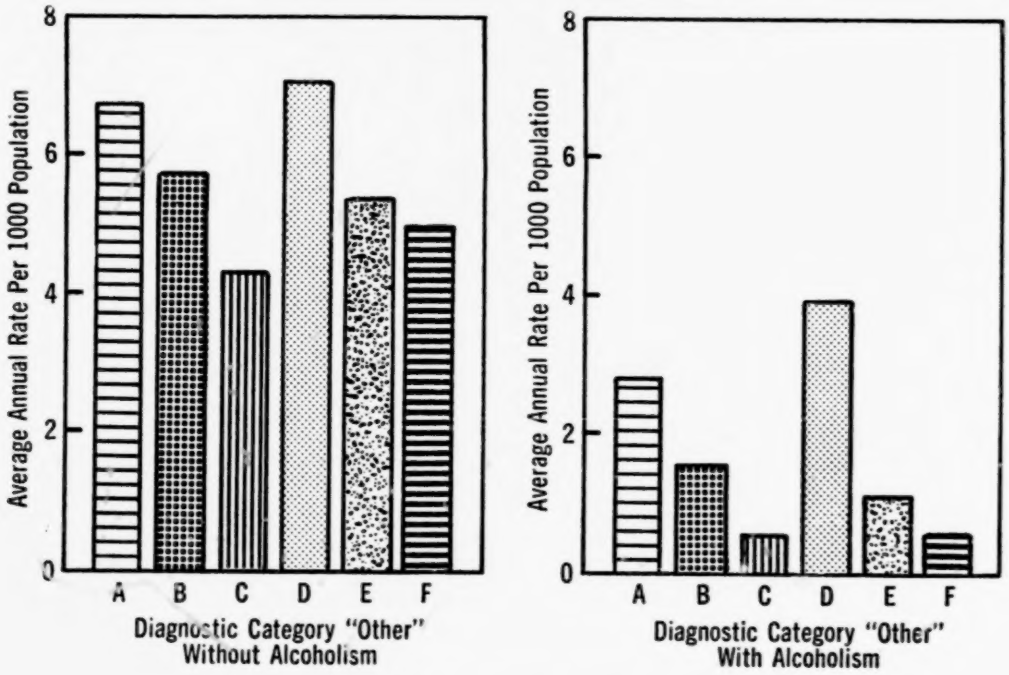
A — Settlement Areas
B — Rochester, Excluding Settlement Areas
C — Monroe County, Excluding Rochester
D — Selected Study Area
E — Control Area I
F — Control Area II

Figure 4. Comparison of Rates of Schizophrenic and Chronic Brain Syndrome for Persons from Areas of Study, Admitted to Psychiatric Service, 1960-1962.

Within the settlement areas, and particularly for the study area, the rates of psychiatric service are higher for whites than for nonwhites (18.4 versus 13.2 per 1000 of the study area population). The same differential is noted within each diagnostic category. However, a contrast obtains for the remainder of the city, excluding the settlement areas, where the rates of diagnosed mental disorder are higher for nonwhites than for whites (12.8 per 1000 versus 8.9 per 1000). This, too, is similar to the findings of Faris and Dunham (1939).

PSYCHIATRIC SERVICE: LONGITUDINAL PATTERNS

To study further the pattern of psychiatric care, we selected two subgroups of patients, one from the study area, and another from the two control areas combined. From each area we selected persons reported to the register between January 1, 1960, and June 30, 1962, eliminating those with a diag-



KEY TO STUDY AREAS

A — Settlement Areas
B — Rochester, Excluding Settlement Areas
C — Monroe County, Excluding Rochester
D — Selected Study Area
E — Control Area I
F — Control Area II

Figure 5. Comparison of Rates of Diagnostic Category "Other" With and Without Alcoholism for Persons from Areas of Study, Admitted to Psychiatric Service, 1960-1962.

nosis of chronic brain syndrome or affective psychosis and anyone with a history of psychiatric contact prior to January 1, 1960. The relatively high mortality rate in the chronic brain syndrome group distorts any longitudinal survey of their psychiatric care. Both groups were followed through the register for an eighteen-month period for subsequent psychiatric care.

During the one and one-half year period, 251 patients from the study area and 358 patients from the control areas met the criteria, with 67 and 52 persons, respectively, receiving a diagnosis of schizophrenia. The remainder were diagnosed as nonpsychotic.

Table 2 presents the pattern of service these patients received after their first report to the register. In examining the distribution of service for the schizophrenics, we note that there are no striking differences in the type of psychiatric care received by the two subgroups. In both groups, a high percentage was hospitalized at some point during the follow-up period (98% from the study area versus 85% from the control area). A greater proportion

Table 2. Comparison of Psychiatric Service for Persons from the Study Area and Control Area, 1960-1962, by Major Diagnostic Category, No Prior Psychiatric Contact

	18 Months Follow-Up Period							
	SCHIZOPHRENIA				NONPSYCHOSIS			
	Study Area		Control Area		Study Area		Control Area	
	No.	%	No.	%	No.	%	No.	%
OUTPATIENT CARE								
Diagnostic Outpatient Contact Only	10	14.9	3	5.8	101	54.9	107	35.0
Treatment Outpatient Contact Only	5	7.5	5	9.6	30	16.3	163	53.3
HOSPITAL CARE								
Diagnostic Outpatient Contact Prior or Following Hospitalization	10	14.9	10	19.2	15	8.2	13	4.2
Aftercare Only—No Pre-Hospital Treatment	27	40.3	18	34.6	12	6.5	8	2.6
Pre-Hospital Treatment With or Without Aftercare	3	4.5	11	21.1	1	0.5	9	2.9
No Outpatient Contact—Only Hospitalization	12	17.9	5	9.6	25	13.6	6	2.0
TOTAL	67	100.0	52	99.9	184	100.0	306	100.0

of the study area group was hospitalized in a public mental hospital (69% versus 49%) in contrast to the greater proportion of control area patients experiencing an inpatient episode in a general hospital (66% versus 41%). Although slightly less than half of those hospitalized patients from each group were readmitted once or more, the study area subgroup experienced a greater proportion of inpatient time than the controls; the former group spent 23% of their follow-up time in a hospital in contrast to the control area patients, who spent 17% of their follow-up period in a hospital.

The pattern of outpatient care does not reflect any striking differences in treatment, although there was a greater tendency for the control area group to receive only outpatient treatment, or outpatient treatment prior to hospitalization. This is in contrast to the study area group, who experienced largely diagnostic outpatient contacts. Approximately one-half of all those hospitalized from each group received aftercare. Because we considered one or more visits subsequent to hospitalization as constituting aftercare, these figures present a better picture than that which exists in fact. Many patients, particularly from the study area group, were seen only once subsequent to hospital discharge.

The pattern of service for the two groups contrasts sharply when we compare the patients who received a diagnosis other than psychosis (Table 2). Twenty-nine per cent of the study area group and 12% of the control area group were hospitalized. Again, more of the former experienced a public mental hospital admission, and a greater percentage of the latter group were at some time hospitalized in a general hospital unit. Approximately 30% of the patients hospitalized from each area were readmitted once or more, but the study area group spent more days in the hospital (8% of their follow-up time versus 5% for the control areas). For the nonpsychotic population, we note a striking difference in the type of outpatient care received by these two groups. More than 50% of the study area group had only a diagnostic outpatient contact. Only 22% of the entire study area group received any kind of outpatient treatment, with or without hospitalization. In contrast, 59% of the control area subgroup received outpatient treatment and approximately 39% of the group experienced only a diagnostic contact.

It appears, therefore, that when a person is recognized as psychotic and is in need of acute care, he will be hospitalized regardless of his area of residence. Although psychotic patients from the higher-income areas are more apt to experience a period of outpatient treatment prior to hospitalization, their overall outpatient care is not strikingly different from that of patients of the lower-income areas. However, the pattern of psychiatric service, particularly outpatient care, differs markedly for an individual who is not psychotic or not recognized as psychotic. (We have noted elsewhere that there is a tendency to underdiagnose psychosis [Babigian, Gardner, Miles, & Romano, 1965].) It is more likely that a person from the higher-income area will receive outpatient treatment only, and the individual from the lower-income area usually will be seen only diagnostically on one or more occasions. Although this can be partially explained by the ability of a higher-income group to pay for private psychiatric care, the discrepancy in the pattern of care remains even when investigation is confined to clinic services: among those persons seen in clinics, the proportion of patients who receive treatment is greater for the control area group than for patients who reside in the study area.

One can argue whether the different kinds of psychiatric care for the two groups is a function of the patient's resistance, his suitability for outpatient treatment, or a bias on the part of the psychiatrist. Nevertheless, the fact remains that the individual from the lower-income area often received inpatient care and, when seen on an outpatient basis, received only brief diagnostic service.

As noted above, the psychiatric care provided to the residents of Monroe County encompasses the full range of traditional psychiatric services. The quantity and quality of psychiatric care available and the sophistication of the population in the use of all health and social services, as well as the pattern of service for the acutely ill psychotic individual, may be atypical for most metropolitan and nonmetropolitan areas.

A New Approach: The Mental Health Team, Its Origin and Operation

With the move of psychiatry into the community, psychiatrists have become more aware of the reservoir of mental illness which goes largely untreated and remains beyond the scope of psychiatric services. In Monroe County, New York, our own experience in a court clinic and in a follow-up study of schizophrenics (Hetznecker, Gardner, Odoroff, & Turner, 1966) supports the belief that there are significant numbers of mentally ill people who are generally managed through nonpsychiatric care. While these persons may or may not come under the purview of a psychiatrist, they usually do not receive continuing psychiatric care. A recent survey, part of the Columbia–Washington Heights Community Mental Health Project, estimated that approximately 70% of the social agency caseloads demonstrate serious psychiatric impairment (Bemmels, 1964). This finding is consistent with the experience of others working with social agencies. The nature of social agency care was investigated by Buell (1952) in St. Paul. The study revealed that 6% of the city population (largely from the inner city) utilized 55% to 68% of the "help services." This demonstrates the marked extent of multiple agency involvement.

When mental illness is not identified or is minimized in these clients, it continues to interfere with the agencies' attempts to help. The workers are left discouraged, frustrated, and often angry at the failure of their clients to respond. When mental disorder is identified, there is usually no ready source of help, unless the illness is severe enough to require hospitalization.

However, the major failures in providing service to these families have been a lack of coordination among the helping services and a discontinuity in care. While the latter may be explained partially by the characterological patterns in this group, it is fostered greatly by the lack of interagency communication and a crisis orientation that focuses on limited aspects of the total disability. In addition, agency workers have been hampered by large caseloads and other limitations of time.

Although, as indicated above, the lower socioeconomic population does not receive adequate care from the traditional psychiatric services, it has become increasingly apparent to all who work in the field of psychiatry that the inadequacies of our present services are never going to be solved by simply more of the same. Likewise, the long sought after panacea-in-a-pill seems more elusive and mythical than ever. Further, psychiatric care is only part of the broader health and welfare needs of these people, and it is difficult to measure the part which psychopathology plays in social pathology, and vice versa (Schorr, 1964).

Thus, it appeared appropriate to test a new approach; namely, a focus on the correlates of psychiatric disorder and social pathology within this group. In January, 1964, after several months of discussion with various community agencies, the Mental Health Team was initiated by the Division of Preventive Psychiatry, Department of Psychiatry, University of Rochester School of Medicine and Dentistry. The year from January to December, 1964, was used as a pilot phase, during which data and impressions were gathered prior to initiating evaluation. Much of the following is drawn from this experience.

THE PROBLEM: DEVELOPMENT OF A NEW SERVICE APPROACH WITHIN CURRENT COMMUNITY ORGANIZATIONAL STRUCTURE

A first question which is raised by this approach must be, "Is a coordinated community approach really a necessity?" or perhaps, "What is wrong with the care being distributed among different agencies organized to deal with specific problems?" One response is supplied by the evidence from multi-agency involvement: families do not have separate, clearly defined problems which can be dealt with in isolation from each other. This is striking in our families, which in the past have been involved with an average of seven agencies and, on occasion, with as many as fifteen different agencies. The lack of communication and coordination among these agencies has been marked despite the presence in the community of an active Central Index for social agencies. It has been a common experience to have agency representatives attending intake conferences of our project express considerable surprise in learning about the number of agencies involved with a given family. Moreover, this involvement is more than superficial: some of our families have received as many as twenty-five home visits from five or more agencies in one month. The financial waste and the inefficient use of worker time, as a sufficient argument for change, is only magnified when one considers the duplication of paper work and supervisory time which is also involved.

More insidious is the effect on the clients. Consider the case of a woman living alone in the inner city with her five preschool and school age children. Her housing is substandard and her housekeeping standards are poor. Because of "junk" accumulated in the house, she is threatened with eviction by the Bureau of Buildings and the Fire Department. At the same time, there is pressure from the Welfare Department to manage on a budget limited to less than the bare necessities of modern life. How, in this situation, can she be expected to respond to the public health nurse's pressure to give more adequate care to her children? Involvement by the Society for the Prevention of Cruelty to Children, with the concomitant threat of removing the children, becomes simply an additional pressure. What can be expected of this woman, who has demonstrated that she cannot bear even the normal pressures of life? Which pressure, which agency, should she consider most significant? In which direction should she move? The result is often paralysis rather than action. And if the housing is substandard, what can be done? The welfare rent payments can be stopped and the woman ultimately forced to move. But there is no one responsible to help her secure new housing, and there are no means of inspecting her new housing until she has already moved.

To whom does she turn for help? Who is responsible for the client? One mother described the six or seven workers regularly visiting her home as "vague figures" who wander in and out, asking many of the same questions but usually referring her requests to "the other" worker who also visits. If one of these vague figures becomes aware of the possibility of mental disorder in this woman, the psychiatric care available is short, crisis-oriented, and more likely to consist of hospitalization than outpatient care. The latter contacts are usually brief and primarily diagnostic. The woman in the above situation might be seen one or two times and receive a diagnosis of inadequate personality, borderline psychosis, or depression, depending upon her presentation of complaints and the diagnostic inclination of the examining physician. With her multiple social problems and her lack of verbal facility, she would be considered a poor case for therapy. She might be considered the proper responsibility of a social casework agency, or she might be sent back into the community to continue the cycle. If there were communication with any agency, it often would not be of any practical help other than the occasional recommendation for hospitalization.

If there is a recognized problem of fragmentation of care, why has it developed, and why have the services not been reorganized?[6] In addition to many other influences, we believe much of the answer lies in the origins of our present services. The welfare organization, for example, is a descendant of the alms house; and many of our welfare laws still embody some aspects of the Elizabethan Poor Laws of 1601. The poor have been considered "sinners," "lacking will," and "lazy"; and they continue to carry the stigma of a disgraceful and loathsome group set apart from society. The view has persisted from the Elizabethan period forward that those who remain poor do not want to work, that the comforts of welfare relief enhance unemployment.

These attitudes persist despite the fact that poverty was shared by millions during the great depression and that this period stimulated some of the current welfare structure. The ideology remains that the poor of the depression era and their contemporary urban-slum counterpart share the same potential to climb up the socioeconomic ladder. But such a comparison ignores the historical and cultural dissimilarities; it forgets the frequent disruption of family life in our present-day inner city life (produced by a multiplicity of factors); and it glosses over the state of chronic depression with its concomittant apathy, hopelessness, and helplessness which this current style of living tends to breed (Schorr, 1963; Wilensky & Lebeaus, 1958; Wiltse, 1963).

The welfare programs were expanded as an emergency measure during the depression of the early 1930's with the optimistic belief that the depression would be resolved shortly. This crisis orientation persists to this day. We have discussed fragmentation of service between agencies; in the Welfare Department there is fragmentation within the structure, as evidenced by Aid to Dependent Children, Old Age Assistance, Aid to the Blind, etc. Many are familiar with the striking paradoxes that may result: it is often easier to receive assistance without a husband in the home or for children born out of wedlock.[7] Frequently aid is more readily available if the husband is declared permanently disabled on a psychiatric basis (Aid to the Disabled), rather than encouraged to view his disability as temporary. Only recently has there been any source of incentive aid for the intact family.

The shock wave of enlightenment during the late eighteenth century, which was produced by the humane movement both here and in England, saw the development of the Society for the Prevention of Cruelty to Children. Ironically, attention was given first to animals with the historic formation of the Royal SPCA by Richard Martin in 1822 and of the American SPCA by Henry Berch in 1866. Only with the famous "Case of Mary Ellen" was concern finally focused on children. The first SPCC was organized by Commodore Elbridge Gerry in New York City in 1874 and was the impetus for most of the child protection laws which followed (Coleman, 1924; American Humane Society, 1962). The gross abuses and maltreatment of children, which generated the creation of the SPCC, no longer exist for the most part; and many of the contemporary problems are more subtle than their counterparts of the previous century. The SPCC still serves primarily as a protective agency, often working with the courts. Essentially it polices families, thus attempting to assure reasonable treatment of children; but the agency suffers from weak and poorly defined laws which frequently restrict its effectiveness (except in extreme cases) and reduce its efforts to threats and temporary action. Any attempts to deal with underlying causes of deviant family behavior are hampered by usually short (even if recurrent) contacts, overworked personnel, and the fact that it is not primarily this agency's responsibility. Additional broad responsibilities thrust upon the Society serve further to obscure its focal function.

---

[6] A detailed discussion of this problem would become enmeshed in the complexly interwoven fabric of American culture. This involves the ethics of individualism, the problems of industrialization, and indeed, the whole problem of bureaucracy. In addition, increased efficiency, social prestige, and other factors encourage specialization, the impact of which is being felt keenly in many areas, particularly in medicine. Such a discussion could easily fill a book, indeed it already has (Wilensky & Lebeaus, 1958).

[7] Although the ADC program was originally conceived in terms of children made dependent by the death or disability of parents, by the end of 1952, among families on ADC rolls, the father was dead in only one case in five. Parental disability was present in only one case in four, and in over half the families on ADC, divorce, desertion, or unmarried motherhood was the cause of child dependency (American Association of Social Workers, 1954). A more recent survey shows that 70% of ADC families in one county included one or more illegitimate children (Greenleigh Associates, 1960).

The Health Department comes closest to providing generalized care for the poor. Traditionally, this care has been oriented primarily toward infectious diseases and general child care. Perhaps the greatest problem of the public health nurse is overgeneralization of her function. She is responsible for school health, rehabilitation services, and child care counseling. In addition, the care is not directed in a concentrated way to those in most need. Despite the fact that the public health nurse may be responsible for the most general care of families, the Health Department has no control over the financial status of these families. Indeed, the medical care of the indigent is regulated by the Welfare Department.

We have dealt with three of the public agencies and have not specifically discussed the voluntary social agencies. Almost all of these agencies face many problems similar to those described above and contribute further to the lack of communication among the service organizations.

What of the role of medicine? Historically, physicians have been morally obligated to treat all the sick, and physicians regularly donate time to the care of the indigent. Clinics have been established for both service to the indigent and the education of physicians. Yet, under the pressure of large caseloads, concern for efficiency may preempt concern for individual patient care. In obstetric clinics, where the relationship of the patient to her physician is recognized as being of crucial psychological importance, patients may be assigned to different physicians on different visits, and indeed, for delivery and follow-up care.

While psychiatry had been concerned primarily with the care of the hospitalized patient, the steady growth of outpatient psychiatry, which we have witnessed in more recent years, is due to a number of factors: the enlightenment of the psychoanalytic movement, the impact of psychiatric services developed during World War II, the recognition of institutionalization and its effects, and the increasing recognition of psychiatric disorders that do not require hospitalization. The source of the enlightenment, however, explains much of the present problem. Analytic theory, upon which most psychiatric care is based, originated in a middle-class setting; and such requirements as verbal facility, persistence, and an introspective orientation, not to mention intact family structure and financial means, are much more typical of the middle class than of the poor (Davis, 1938; Freud, 1962). The development of psychiatric clinics has not generally lessened the demand for the other requirements. As we attempt to apply a mental health model, developed in a specific cultural climate, to a broader range of cultures, we face the difficulty of differentiating cultural values from mental illness. These problems were recognized by Kingsley Davis in the earlier development of the mental health movement and by others more recently (Davis, 1938; Gursslin, Hunt, & Roach, 1959; 1964; American Association of Social Workers, 1954). The frustration of applying inappropriate therapeutic techniques because of inappropriate expectations usually leads the patient or therapist to terminate.

OPERATION AND EVALUATION

The approach of the Mental Health Team centers on the multiproblem family as a prototype of the family presenting the previously defined correlates. Frequently, such families have had some psychiatric contact, and it is our impression that one or more members of a large percentage of these families is psychotic or marginally compensated. In 39 of the 55 families (71%) referred to the Team during the year's pilot study, at least one member had experienced a psychiatric contact in the past five years. Although it may be argued that our criteria for referral bias this sample, we would point out that roughly one in every 15 persons in this inner city population has had a reported psychiatric contact in a three-year period. Our statistics are even less surprising if computed on the basis of families rather than individuals.

The Mental Health Team, which is based within a settlement house, though its operations are totally distinct from that agency, functions as a training base for both the psychiatrists and agency workers. The Team consists of seven workers on half-time loan from the following agencies: Department of Social Welfare (one); Baden Street Settlement house, Volunteer Case Aide Division (one); Health Department (two); Psychiatric Court Clinic (one); Society for the Prevention of Cruelty to Children (one); Family Service Center (one). At present there are four psychiatrists (residents and staff from the Division of Preventive Psychiatry of the University of Rochester Medical Center) who are active with the Team.

Referrals to the Mental Health Team are accepted from any social agency, school, court, psychiatric service, the Department of Health, and the social service department in any of the hospitals in the community. The criteria for referral are somewhat narrow: they have emerged, in part, because of the lack of any generally accepted referral criteria in the field, and in part because of the limitations imposed by the research evaluation. Were a Team approach to become an established service, these criteria could be expanded.

At present the referral criteria are as follows:

1. All referred families must live within one of the 36 census tracts that comprise the inner city, encompassing the settlement areas.
2. A family is defined as consisting of at least one parent and two children, with at least one child in elementary grades 1-5.
3. "Multiproblem" is defined as contact with at least two or more agencies, currently or during the previous six months. At least one of these agencies must be the Department of Welfare, the Society for the Prevention of Cruelty to Children, or the Department of Health.
4. At least one parent is considered to have significant mental illness in the judgment of the referring worker. Diagnosis by a psychiatrist is not required.
5. All agencies active with the referred family at the time of referral must be willing to terminate their relationship.

All referrals meeting the foregoing criteria are scheduled for our intake conference, which is attended by the referring agency and all community agencies actively engaged, or having had recent contact with the family, and by a Team worker and a psychiatrist who are paired in rotation to each case. Subsequently, the Team worker makes four or more home visits to the family, during which time she collects detailed historical data and information on present problems and records observations on the psychological status of the family. Then the Team worker introduces the family to the psychiatrist, who visits one or more times and conducts a diagnostic evaluation. A reevaluation conference is then scheduled, with the whole Team and the involved agencies participating. During the evaluation period these agencies maintain their usual involvement with the family, and the Mental Health Team is presented as consultants to the agencies.

A family which is found to meet all the criteria is then assigned on a random basis to the Team or to a control group. With assignment to the control group, agencies continue their previous patterns of service; and the Team terminates contact. If the case is assigned to the Team, all agencies terminate their relationship with the family, as outlined in criterion 5 above, and the Team assumes full responsibility for further care. Thus, we initially coordinate the agency activities through the intake process, and for active cases, continue the coordination operationally by assigning to the Team worker total responsibility for each family.

The approach is an active one in which we bring care to the family through home visits, either with the family as a unit or with the individual members separately, and occasionally actively pursue reluctant patients. We utilize social manipulation, which frequently involves mediating the actions of various government agencies upon the clients, as well as various modalities of psychotherapy; and we are prepared to follow members of these families through a hospital admission. Therapy is at times uncovering and insight-directed, but most often it is supportive in nature. In addition, medication is used under the psychiatrist's direction. The psychiatrist functions as a supervisor on the case, meeting regularly with the worker and revisiting the family periodically to reassess their needs.

A detailed description of one case (the E family) may serve to illustrate quite concretely the operation of the Team.

This couple and their four children were referred by the Department of Welfare shortly after the birth of their fourth child. The E's had received public assistance intermittently during the past several years and were well known by the caseworker responsible for their district, part of the more deteriorated slum area in the central city. The worker could recognize Mrs. E's severe depression and was aware that Mr. E was drinking heavily and contributing little or no financial support to the family. Mr. E had injured his arm approximately one year previously; he was awaiting a decision regarding compensation and now used this as the reason for his drinking.

Mrs. E appeared to be an ineffectual bedraggled woman, looking considerably older than her stated age, incapable of dealing with her husband, children, or household duties, and seemingly oblivious to it all. Two generations of her family were known to the Department of Welfare; and Mrs. E viewed herself as another in the line of public dependents, doomed to a life of unhappiness and fortunate to have any husband, despite his abusiveness and alcoholism.

Some neighbors had reported the E family to the SPCC, but the latter agency did not believe there was sufficient abuse or neglect to warrant any action. The oldest daughter presented a problem at school in that she usually was unkempt, occasionally filthy, and at times complained of not having sufficient food. Nevertheless, she presented no marked behavioral problem and obtained passing grades or better.

At the time of referral to the Team, a public health nurse had visited the home several times to guide Mrs. E in the care of the baby. Although the nurse spent most of her time discussing the baby's formula and the problems of feeding, she had been particularly impressed by the baby's unresponsiveness and listlessness. He was gaining weight satisfactorily and showed the proper motoric development but, even at age five months, he could be characterized as withdrawn. The nurse had wanted the baby seen at a pediatric clinic but had been unable to arrange this, due partially to Mrs. E's apathy and, perhaps, reluctance.

Though a number of agencies were involved with the E family, no one worker visited them regularly; nor was any one person familiar with the full pattern of their problems. The Department of Welfare caseworker had known the family for the longest length of time but saw them infrequently since they were not continuously receiving public assistance. Mrs. E viewed each worker as someone who would help with a specific problem or category of problems but saw no one as a confidante with whom she might discuss major concerns, such as her husband's alcoholism. Mr. E viewed all "caretakers" with suspicion. He saw them as people who were there largely to check on him. To him, all such visitors were authority figures to be deceived and manipulated to get "what was coming to him."

When the E family was referred to the Mental Health Team, the intake conference was attended by the referring caseworker and her supervisor from the Department of Welfare, the public health nurse and her supervisor, a worker from SPCC, the school social worker, a policewoman who had helped with the family disputes in the past, and a volunteer from a church-sponsored program for low-income families. A fairly complete history and picture of the family emerged at the conference, though no single person seemed to be well acquainted with the family. Because of the apparent lack of affect described in Mrs. E and her occasionally confused, perhaps "peculiar" behavior, there was some discussion as to whether she might be schizophrenic. Although no final diagnostic judgment was made at the conference, the possibility of hospital admission for Mrs. E was considered.

One of the public health nurses from the Mental Health Team was assigned to the E family and introduced as a replacement for the nurse who had been visiting. After three visits by the Team nurse, both she and a psychiatrist saw the entire E family twice and subsequently presented their evaluation at the diagnostic conference. They were both struck by the apathy and almost total lack of self-care manifested by all members of the family. The apartment in which they lived obviously had not been cared for by the landlord or the E family. The walls were discolored, spotted, cracked, and had large sections of plaster missing or ready to fall. The windows could not be opened, contributing to the overwhelming stench that greeted anyone upon first entering the apartment. The floors were warped, covered with debris. There was little closet or cabinet space, and it appeared that most of the family's belongings had been randomly scattered about the furniture and floors. The scarce furniture present was old, dusty, marred, and torn. But most striking of all was the general filth that covered the members of the E family.

Mrs. E appeared, on the basis of the initial contact period, to be severely depressed but not psychotic. This seemed to be related to her pregnancy and the postpartum period; however, the duration of the depression was difficult to delimit. Though she expressed the usual concerns about the baby, she virtually ignored him during the course of each interview. Both the nurse and psychiatrist had the impression that no one in the family said more than a few words to the baby throughout the day.

Although Mr. E had a superficial friendliness, he obviously disliked the visits by the nurse and was particularly threatened by the psychiatrist. He usually would be out at the time of the Team member's visit, occasionally drinking with his cronies. When the Team members waited for him to return, he would be annoyed by this and would search for reasons to terminate the visit quickly. He fluctuated between moments of gruffness with threats toward Mrs. E and periods of bemoaning his arm injury, his inability to work, and his fate in general.

When the E family was assigned to the Mental Health Team for continuing care, the other agency workers willingly agreed to withdraw or to maintain minimum contact. Despite this ostensible willingness and their complaints about the E family, it was interesting to note that some workers later showed resentment about "their case" being taken from them.

The Team worker (nurse) began visiting the E family weekly, occasionally twice a week. She left both her work and home phone numbers for Mrs. E to call whenever necessary. The psychiatrist visited, jointly with the worker, approximately once a month and, occasionally, received calls from Mrs. E when the worker could not be contacted. Although the nurse tried to explain the operation of the Mental Health Team to the family, it was doubtful that this was fully understood. She probably was viewed as a public health nurse, with the psychiatrist seen as some type of consultant or supervisor.

During the first several visits the worker spent most of the time listening to both Mr. and Mrs. E relate their problems and, when specifically questioned, discuss their backgrounds. Both she and the psychiatrist tried to sort out the most pressing needs from the maze of problems presented by the family and to choose the best initial approach. It was thought Mr. E needed help in quickly getting his compensation case resolved and then in obtaining full-time employment. An effort was made to give him a more active role in the family, in the discipline of the children, repair of the apartment, etc. With Mrs. E the worker acted more as a sympathetic listener, giving advice, when asked, in regard to the children, the budget, and purchase of food and discussing Mrs. E's negative self-image with her. When the E's complained about the deteriorated state of their apartment, the worker contacted the landlord and tried to have repairs made. When he resisted, the Department of Welfare was notified to withhold rent payments and to look for another apartment.

The most rapid and noticeable effect of the Team worker's efforts was the change in Mrs. E. Within two months she was relating quite dependently to the worker and obviously looking forward to her visits. She brightened considerably, emphasizing the degree of her previous depression. She became more sociable, showed much more interest in her own appearance, and started to take much better care of the children and the apartment. Both the worker and the psychiatrist were surprised by Mrs. E's attractiveness as she gave more attention to her personal care.

In contrast to Mrs. E's improvement, Mr. E seemed to deteriorate further. He began to drink continuously, became physically abusive toward his wife, and began to accuse her of going out with other men. Mr. E's lawyer, when contacted by the worker, viewed our efforts to settle the compensation case rapidly as an infringement on Mr. E's right to gain the best possible settlement. He indicated, however, that contrary to Mr. E's statements, there was no reason not to seek full-time employment while awaiting settlement.

Mr. E's ineffectuality was perhaps best demonstrated by one incident. While the worker and psychiatrist were visiting, a fire started in the next apartment. Although the fire was brought under control quickly by the Fire Department, the E family and the Team members had to evacuate furniture and clothing from two rooms to protect them from water damage. In contrast to Mrs. E and the older children, who did not panic, Mr. E became paralyzed. He stood in the kitchen, crying openly, trembling and complaining of his fear of reinjuring his arm. He finally had to be led from the apartment.

Subsequent to this incident, the E family had to be moved into temporary quarters while a new apartment was located. During this period the Team worker kept in close contact with the Department of Welfare caseworker and with the Bureau of Buildings. The E family was encouraged to look for quarters themselves, and arrangements were made to care for the children. When a new apartment was located, the family appeared to be stimulated by this and seemed to enjoy painting, cleaning, etc. Soon, however, Mr. E resumed his drinking, again became abusive, and began to have his drinking companions board with the family for two or three days at a time. Efforts to involve him in therapy on an outpatient basis or to have him admitted to the hospital drew only further complaints about his arm. Appointments with a physician were not kept.

It was apparent that the tenuous marital balance could be maintained only with Mrs. E in an inferior, passive role or with considerable support for Mr. E's easily threatened masculinity. The complications presented by the pending compensation, the somewhat realistic difficulties in obtaining suitable unskilled employment, and his long standing alcoholism all precluded much support for Mr. E. Thus, further efforts to resolve the marital stress were discontinued and attention directed toward Mrs. E's talk of separation. Although she had spoken of this for some time, her fear of being alone and the image of herself as an ineffective, disorganized individual deterred any move toward separation. She also feared Mr. E's threats about keeping the children. With support from the Team worker and her increasing confidence and assertiveness, Mrs. E was directed to Family Court to prepare for the separation. Another apartment had to be located and plans made to divert welfare funds from Mr. E to Mrs. E and the children.

It was apparent that Mr. E was using most of the welfare money for his drinking. Though threatened with loss of welfare support, Mr. E refused to move from the apartment, continued his drinking, and became more assaultive. After considerable discussion and several meetings of everyone concerned, an order of protection was obtained. Mrs. E and the children were moved to another apartment; public assistance payments were transferred to her; and temporary quarters were obtained for Mr. E at the County Home. He was soon arrested for public intoxication, however, and arrangements were made via psychiatric consultation to the City Court for admission to the County Infirmary.

Although Mrs. E made all the necessary contacts herself, through the entire period she depended on the Team worker for guidance and support. She particularly had to discuss her ambivalence toward Mr. E, her guilt about leaving him, and her feeling that she was bound to suffer and might as well not resist it. The worker frequently had to maintain coordination between the agencies and interpret their activities for Mrs. E. At times, the authority of the Team's psychiatrist was required to facilitate certain action.

Subsequent to the separation and move, the change in Mrs. E and the children was remarkable. Although she first called the Team worker frequently for reassurance, this subsided and Mrs. E began to call only in emergencies. She became much more outgoing, independent, and cheerful. She claimed that she had never felt better. Her new apartment was decorated tastefully, as she took obvious pride in its appearance. The children appeared brighter, more sociable, and more talkative, both in school and during visits with the Team worker.

Mr. E resumed his drinking when discharged from the hospital and again entered the County Home. His lawyer was more agreeable to a quick resolution of the compensation case, but this now awaited an improvement of Mr. E's condition.

A year after the first contacts with the Team, the worker was visiting Mrs. E every two to three weeks and receiving calls from her only rarely. The Department of Welfare caseworker saw Mrs. E. every few months and then briefly conferred with the Team worker. Other than this, no other agency or worker had any contact with the E family.

EVALUATION

The pilot study period in 1964 was used to accumulate experience and to plan for an evaluation procedure to study the impact of the Mental Health Team intervention. From the one year's experience, it became apparent that there were two major areas to be evaluated: (1) *The reduction of mental disorder in the children of Mental Health Team families.* Through our intervention with these families we hoped to bring about stabilizing influences in the environment of the children, especially through changes in the attitudes and behavior of the parents. Thus, one major component of the entire evaluation procedure was the measure of longitudinal behavioral changes in the children at school and at home. (2) *Reduction in the psychopathology and disability manifested by the adult members of the Mental Health Team families.* Although our primary goal was the reduction of mental disorder in the children, we did wish to correlate these latter changes with any concomitant behavioral alteration in the adults.

The evaluation period began in September, 1965, and at that time, all families referred to the Team, who met the criteria outlined above, were randomly assigned to the experimental group or control group, each of which consists of 35 families. The families of the experimental group were assigned to a Mental Health Team worker and psychiatrist for the usual follow-up care. The control group families were seen by independent evaluators, who obtained the necessary historical data and administered the various questionnaires; they were then referred back to the referring agencies for further care, but were to be followed at six-month intervals by the evaluators.

Much of the data for evaluating any changes in the children of the Mental Health Team families will be gathered in the school setting. We have attempted to avoid bias on the part of teachers or others evaluating these children by testing all, or part, of each class containing any children from the Mental Health Team families. This third group of children, a control group, will also allow us to evaluate the impact of the testing situation upon all of the children. Furthermore, it will provide us with data about the kinds of behavior that may be expected from this population and, therefore, give us a much better basis for refining further our various instruments.

The evaluation of change in the children will derive from the data obtained in three settings: (1) school, (2) home, and (3) community. We will use information already available such as school grades, attendance reports, delinquency records, etc., in addition to the data collected using various rating scales and objective tests. The latter include a teachers' behavior rating check list (Cowen, Izzo, Miles, Telschow, Trost, & Zax, 1963) and the Children's Manifest Anxiety Scale–CMAS (Castaneda, McCandless, & Palermo, 1956).

Evaluation of adults will focus on behavioral changes both in the community and within the home and family setting. Again, we will make use of the data already available in addition to the information obtained from our interviews. Several more objective assessment procedures, including a behavioral and mental status check list (Hetznecker, et al., 1966) and a maternal attitude to child-rearing scale (Glidewell, 1961), will be utilized in this context.

A PROPOSAL FOR REORGANIZATION

The response from many in psychiatry, when confronted with the problems presented by the poor, has been, "It's not our problem. It's a problem for society" (Berlin, 1964, p. 801). We have stated that psychiatric care is only a part of the broader health and welfare needs of the lower class. In addition to any service approach, more far-reaching changes, legislative and cultural, may be required to provide the ultimate solution to their needs. Despite this, we believe that much can be accomplished through direct service, given our present state of knowledge in the behavioral sciences.

A psychiatric approach, however, whether it be community mental health centers, home visiting teams, or rehabilitative services, if isolated from the other helping services, will continue to fail in its service to the poor. There is much inherent in the present organization of services which prevents good care. We have attempted to outline the characteristics of the organization and some of its origins. What then do we propose? This could, in part, be indicated in the demonstration project described; we might suggest that a mental health team or a comparable structure be added to the present organization of community agencies. But this would be a partial and temporary response. Indeed, our present Team, although it exists only as part of a demonstration project whose stated purpose is temporary, has felt the pressure toward permanence due to the community's unsatisfied need for service. The rapid assimilation of a new group such as the Mental Health Team as a viable structure reflects the fact that existing agencies concerned with the problems of the poor are typified by considerable organizational confusion.[8] Some of the present agencies may, in fact, have arisen as demonstration projects, only to be rapidly assimilated into the overall community organizational scheme as permanent structures with their own territorial rights and responsibilities.

Despite the general acceptance of the Team and the desire to cooperate, often to the point of stretching legal limits, a basic conflict of interests and operating principles often exists between the Team and other agencies. Such divergent approaches have, on occasion, defeated the attempt at coordination and continuity of care. The Mental Health Team, in part, does represent an addition to the present organization of services, and to that degree, poses similar problems.

An alternative proposal might call for centralization at administrative levels, and such has been accomplished partially in one area (Chope & Black-

[8] These problems and the need for coordination were noted by Warner, Queen, and Harper (1930) at the turn of the century. They state, "Thus we find on every hand evidence of the acceptance of the principle of coordination but considerable difference in opinion as to how far it should be carried and as to the methods of putting it into effect."

ford, 1963). Although this can reduce duplication in record keeping and increase communication among workers in various roles, it does not resolve the primary problem. Families are still shunted between the various services. Each service assumes temporary responsibility for coordinating all efforts. Although continuity and improved communications are necessary at the administrative level, they are of crucial importance at the operational level.

We would propose, therefore, a drastic reorganization of the helping services and would envision a central agency with broad responsibilities for the health, education, and welfare of the community. At the operational level, service would be provided via teams, distributed geographically throughout the city, with total responsibility for the care of the population within their designated areas. While the make-up of such teams might vary, they should have supervisory and consultative personnel of a broad and varied nature, including psychiatric, welfare, legal, and medical services, as required. In some situations, several teams could share supervisory personnel. Most importantly, the team workers would be responsible for the total social-medical care of the assigned families. These services could be interwoven into a more complete system of day-night services, outpatient clinics, and hospital wards such as have been proposed elsewhere (Babayan, 1965; Joint Commission on Mental Illness and Health, 1961).

It should be noted that under the reorganization we propose, the particular knowledge and skills gained in specialized areas, as developed by the community structure, would not be wasted; on the contrary, they would be put to more efficient use. Effective worker time would be likely to increase despite the increased time initially required for each case. In addition, other sources of personnel from relatively untapped sources may become more accessible and more useful. Our own use of volunteer case aides is one example.

What we propose may appear, at best, idealistic and utopian. We also are well aware of the vested interests which have developed in entrenched organizational structures and the usual resistance to change. But we are convinced that without a radical reorganization of services at all levels, future programs are bound to fail, despite the astronomical sums of money and personnel time which are channeled into such programs. Stated in another way, it is an issue not only of personnel but of organization.

SUMMARY

Using the psychiatric case register, rates of diagnosed mental illness for patients from lower socioeconomic areas were compared with those for patients from higher socioeconomic areas of Monroe County, New York. Regardless of the area of residence, patients diagnosed as psychotic and in need of acute psychiatric care (schizophrenics) usually are hospitalized. Our data, generally consistent with those reported elsewhere, indicate that despite comparable rates of hospitalization for all socioeconomic groups, and despite the overrepresentation of the lower class in all reported psychiatric illnesses, the rate of outpatient therapy received by lower-class individuals is about one-third the rate of the rest of the population. Further, those who contacted outpatient services and were not diagnosed as psychotic received a strikingly different pattern of care; the group from the lower socioeconomic area experienced mainly diagnostic contact, while the group from the higher socioeconomic area frequently received therapeutic service.

We have focused on the fragmentation of care and the lack of coordination of helping agencies. We then described a project currently active in Monroe County, New York, which demonstrates an attempt to coordinate services and give total care to multiproblem families.

The discussion raised some questions as to why the present organization of psychosocial services fails to meet the needs of the lower class. We attempted to answer this question by describing the pattern of care, and we explored the origin of our present patterns of psychosocial care historically. It has been noted that various services are no longer applicable to our current situation. We explored several possible methods of improving the services to the poor and argued that what is needed is a radical reorganization of the patterns of psychosocial care. Such reorganization would make more efficient use of personnel and money; it would be guided by the needs of the population served rather than by the demands of an antiquated organization of services.

REFERENCES

American Association of Social Workers. *Social work year book.* New York: Author, 1954.

American Humane Society. *The national humane review.* Golden anniversary issue. 1962, 50, 4-98.

Auld, F. Jr., & Myers, J. K. Contributions to a theory for selecting psychotherapy patients, *J. clin. Psychol.*, 1954, *10*, 56-60.

Babayan, E. E. The organization of psychiatric services in the U.S.S.R. *Internat. J. Psychiat.*, 1965, *1*, 31-35.

Babigian, H. M., Gardner, E. A., Miles, H. C., & Romano, J. Diagnostic consistency and change in a follow-up study of 1215 patients. *Amer. J. Psychiat.*, 1965, *121*, 895-901.

Bemmels, V. G. Survey of mental health problems in social agency caseloads. *Amer. J. Psychiat.*, 1964, *121*, 136-147.

Berlin, I. N. New directions in AOA—one view. Editorial in *Amer. J. Orthopsychiat.*, 1964, 34, 801.

Brill, N. Q., & Storrow, H. A. Social class and psychiatric treatment. *Arch. gen. Psychiat.*, 1960, 3, 340-344.

Buell, B. et al. *Community planning for human services.* New York: Columbia, 1952.

Castaneda, A., McCandless, B. R., & Palermo, D. S. The children's form of the manifest anxiety scale. *Child Developm.*, 1956, 27, 317-326.

Chope, H. D., & Blackford, L. The chronic problem family: San Mateo County's experience. *Amer. J. Orthopsychiat.*, 1963, 33, 462-469.

Coleman, S. H. *The humane society leaders in America.* Albany, N. Y. The American Humane Association, 1924.

Cowen, E. L., Izzo, L. D., Miles, H. C., Telschow, E. F., Trost, M. A., & Zax, M. A preventive mental health program in the school setting: Description and evaluation. *J. Psychol.*, 1963, *56*, 307-356.

Davis, K. Mental hygiene and the class structure. *Psychiatry*, 1938, *1*, 55-65.

Faris, R. E. L., & Dunham, H. W. *Mental disorders in urban areas.* New York: Hafner, 1939.

Freud, S. *Collected papers.* Vol. 1. On psychotherapy. London: Hogarth Press, 1962. Pp. 249-263.

Gardner, E. A., Miles, H. C., Bahn, A. K., & Romano, J. All psychiatric experience in a community. *Arch. gen. Psychiat.*, 1963, *9*, 369-378.

Gardner, E. A., Miles, H. C., Iker, H., & Romano, J. A cumulative register of psychiatric services in a community. *Amer. J. publ. Health*, 1963, 53, 1269-1277.

Glidewell, J. C. *Parental attitudes and child behavior.* Proceedings of second annual conference on community mental health research. Springfield, Ill.: Charles C Thomas, 1961.

Greenleigh Associates, Inc. *Facts, fallacies and future: A study of the aid to dependent children program of Cook County, Illinois.* New York: Author, 1960.

Gursslin, O. R., Hunt, R. G., & Roach, J. L. Social class, mental hygiene and psychiatric practice. *The Social Service Rev.*, 1959, 33, 237-244.

Gursslin, O. R., Hunt, R. G., & Roach, J. L. Social class and the mental health movement. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor.* New York: Free Press, 1964. Pp. 57-67.

Harrington, M. *The other America.* Baltimore, Md.: Penguin, 1962.

Hetznecker, W., Gardner, E. A., Odoroff, C. L., & Turner, R. J. Field survey methods in psychiatry: A symptom check list, mental status and clinical status scales for evaluation of psychiatric impairment. *Arch. gen. Psychiat.*, 1966, *15*, 427-438.

Hollingshead, A. B., & Redlich, F. C. *Social class and mental illness.* New York: Wiley, 1958.

Hunt, R. G. Social class and mental illness: Some implications for clinical theory and practice. *Amer. J. Psychiat.*, 1960, *116*, 1065-1069.

Imber, S. D., Nash, E. H., & Stone, A. R. Social class and duration of psychotherapy. *J. clin. Psychol.*, 1955, *11*, 281-284.

Joint Commission on Mental Illness and Health. *Action for mental health.* New York: Basic Books, 1961.

McMahon, J. T. The working class psychiatric patient: A clinical view. In F. Reissman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor*. New York: Free Press, 1964. Pp. 283-302.

May, E. *The wasted Americans*. New York: Harper & Row, 1964.

Myers, J. K., & Schaffer, L. Social stratification and psychiatric practice: A study of an outpatient clinic. *Amer. soc. Rev.*, 1954, *19*, 307-310.

Schaffer, L., & Myers, J. K. Psychotherapy and social stratification. *Psychiatry*, 1954, *17*, 83-93.

Schorr, A. L. *Slums and social insecurity*. Washington, D.C.: U.S. Dept. of H.E.W., Social Security Administration, Division of Research Statistics, 1963.

Schorr, A. L. Non-culture of poverty. *Amer. J. Orthopsychiat.*, 1964, 34, 907-912.

Srole, L., Langner, T. S., Michael, S. T., Opler, M. K., & Rennie, T. A. C. *Mental health in the metropolis: Midtown Manhattan study*. Vol. 1. New York: McGraw-Hill, 1962.

Warner, A., Queen, S., & Harper, E. *American charities and social work*. New York: Crowell, 1930 (first edition, 1894), Chap. 31.

Wilensky, H. Z., & Lebeaus, C. W. *Industrial society and social welfare*. New York: Russell Sage Foundation, 1958.

Wiltse, K. T. Orthopsychiatric programs for socially deprived groups. *Amer. J. Orthopsychiat.*, 1963, 33, 806-813.

Winder, A. E., & Hersko, M. The effect of social class on the length and type of psychotherapy in a Veterans Administration mental hygiene clinic. *J. clin. Psychol.*, 1955, *11*, 77-79.

12

A MENTAL HEALTH CONSULTATION PROGRAM IN A SMALL COMMUNITY WITH LIMITED PROFESSIONAL MENTAL HEALTH RESOURCES[1]

Charles D. Spielberger
Florida State University

It is estimated that over 19 million people in the United States, or about 1 in 10, have emotional problems that require professional attention. The magnitude of the mental health problem in this country is further demonstrated by the fact that approximately 1 out of every 2 hospital beds is occupied by a mental patient. These statistics, which by now are quite familiar to all of us, do not include the nearly 5 million mentally retarded children and adults who also require special professional services and, in many cases, institutional care. Yet, in contrast to the number of persons who are in need of assistance, the professional manpower resources available for helping individuals with mental and emotional problems are extremely limited.

On the basis of nationwide studies of mental health manpower needs, it appears likely that we will continue to be faced with serious personnel shortages in all of the professions now counted upon to provide mental health services (Albee, 1959). Acute shortages in trained mental health manpower are perhaps nowhere more evident than in areas located at some distance from large metropolitan centers and training institutions (Libo & Griffith, 1966). Several years ago, the writer was asked to assist a small urban community with limited professional mental health resources in developing a mental health program. The program described in this chapter was evolved in the course of working in this community with key professional groups such as public health nurses, ministers, teachers, and community leaders over a four-year period.

---

[1] Some of the ideas expressed here were first presented in a report to the New Hanover County Association for Mental Health in Wilmington, North Carolina, 1959, and in a symposium at the American Orthopsychiatric Association Meetings in New York City, 1961. I am most grateful to John Altrocchi and Warren C. Lamson for their helpful comments and suggestions on early drafts of this chapter.

THE COMMUNITY SETTING IN WHICH THE CONSULTATION PROGRAM WAS DEVELOPED

In the fall of 1958, at which time the writer was a member of the Psychology Faculty of Duke University in Durham, North Carolina, he was invited to become a consultant to the Association for Mental Health and the Consolidated Health Department of Wilmington and New Hanover County, North Carolina. Wilmington, the principal seaport of North Carolina, is located on the Cape Fear River in the southeastern corner of the state. At the time the consultation relationship was established, New Hanover County had a year-round population of about 75,000 people, concentrated largely in the city of Wilmington and its suburbs; the county's population was considerably greater in the summers with an influx of vacationers to the popular resort areas at Wrightsville Beach and Carolina Beach.

A child guidance clinic with a professional staff consisting of a single part-time psychiatrist had been established in Wilmington in 1947. Unfortunately, it had been necessary to discontinue the operations of this clinic in 1949 when the psychiatrist departed and it was not possible to secure other qualified staff. From 1949 until 1957, there had been no active community organization or agency that invested its major energies and resources in coping with mental health problems; those problems that could not be handled by individuals or agencies in the community had been referred to distant diagnostic and treatment facilities. The nearest comprehensive mental health facilities were located at the university centers in Chapel Hill and Durham, both approximately 150 miles from Wilmington.

The New Hanover County Association for Mental Health was formed in 1957. This group had strong backing from the community and readily obtained financial support from the United Fund. In collaboration with the staff of the Health Department, the Association set about to develop a mental health program. To implement this program, a position was created for a full-time clinical psychologist on the staff of the Health Department. This position was filled on a part-time basis in the summer of 1958, but remained filled for only six months. During this time, there were constant pressures to provide clinical services.

In November, 1958, shortly before the departure of the part-time psychologist from the Health Department staff, the writer made his first consultation visit to Wilmington. Almost immediately the Health Department received requests for diagnostic psychological examinations and inquiries concerning the possibility of referring patients for treatment. This was not surprising since there was only one mental health professional residing in the community, a psychiatrist who served not only New Hanover County but also the surrounding areas in North and South Carolina with an aggregate population of over a quarter-million people. The psychiatrist's practice was, of necessity, limited primarily to the treatment of the more serious manifestations of mental disorder.

Initially, it was determined that the consultant would spend one day each month in the community, but after four months this was increased to two days per month. It was also agreed at the outset (with representatives of the Mental Health Association and the Health Department) that the consultant's limited time would be used sparingly for providing direct services to individual patients. Instead, the emphasis of the program was to be on the promotion of mental health and the prevention of mental illness through consultation with key professional workers. In addition, we hoped to stimulate, to the maximum possible extent, the active concern and involvement of all facets of the community in mental health problems. Elements of the mental health consultation program that evolved will be discussed in detail, but first we should consider the general principles of mental health consultation that guided the program and describe the method of group consultation that was developed as the primary mechanism for its implementation.

PRINCIPLES OF MENTAL HEALTH CONSULTATION

Growing interest in the prevention of psychological disorders and the promotion of mental health in the past decade have led mental health specialists to engage in a wide variety of consultation activities. Gerald Caplan and his associates have pioneered the development of mental health consultation practice and the formulation of consultation theory (e.g., Bindman, 1959; Caplan, 1964). Caplan's approach focuses upon providing consultation for key professional workers in disciplines other than those generally called upon to cope with problems of mental health and mental illness. Included in the professional groups with whom Caplan and his colleagues have worked are pediatricians, teachers, clergymen, social workers, and nurses. In principle, any person or member of a profession that performs important "caretaking" services in a community is a proper target for mental health consultation.

Mental health consultation has been defined as "a helping process, an educational process, and a growth process achieved through interpersonal relationships" (Rieman, 1963, p. 85). Through mental health consultation, the mental health specialist may assist the key professional workers of a community in becoming more sensitive to the needs of their clients and associates and more comfortable in their relationships with them. Ministers, physicians, lawyers, public health nurses, and members of numerous other professional groups are often called upon by the individuals with whom they work in times of personal and interpersonal crises. Mental health consultation theory holds that crises provide opportune times for a sensitive professional to be of significant assistance to those who seek his services (Caplan, 1964). By promoting the mental health of their clients and by helping to restore emotional equilibrium in disturbed clients, members of key professional groups can reduce the number of persons who are likely to develop serious mental disorders.

In essence, mental health consultation provides a mechanism whereby the mental health specialist may assist the caretaking agents of a community so that the latter, within the framework of their usual professional roles, can better utilize mental health principles. While the major goal of mental health consultation is to assist other professionals in handling, with greater effectiveness, certain emotional problems of their clients, important subgoals are to help persons in key professions better to recognize the symptoms of mental illness and to assist them in making appropriate referrals to mental health specialists when this is required. It should be noted, however, that the mental health consultant does *not* attempt to teach specialized mental health techniques (e.g., psychodiagnosis, psychotherapy) to members of the key professional groups with whom he works.

The theory and practice of mental health consultation have been concerned primarily with interactions between a consultant and a single consultee (Bindman, 1959; Caplan, 1964). Typically, a relationship is established in which the consultee, a member of a key professional group, may call upon a consultant for assistance with a problem that has been stimulated by one of the consultee's clients. The consultant, most often a well-trained specialist on the staff of a nearby mental health facility, then arranges a consultation in which the client's problems and the consultee-client relationship may be discussed. In Wilmington, restrictions imposed by the fact that the consultant's activities in the community were limited to two days per month rendered "on-call" response to individual consultee crises impractical. Furthermore, the active interest in mental health problems of a large number of key professionals in the community, as reflected in numerous requests for assistance, suggested that it would not have been possible to respond to these requests on an individual basis. Therefore, a case-seminar method of mental health consultation with groups was developed as our principal consultation procedure.

CASE-SEMINAR METHOD OF MENTAL HEALTH CONSULTATION WITH GROUPS

The case-seminar method of mental health consultation[2] consists of regularly scheduled group meetings in which a mental health specialist consults with members of a key professional group. Group members generally

[2] Many of the ideas on the case-seminar method of group mental health consultation that are discussed in this chapter were developed in collaboration with John Altrocchi and Carl Eisdorfer, to whom the writer is deeply grateful. For a more detailed theoretical treatment of mental health consultation with groups, the reader is referred to the paper by Altrocchi, Spielberger, and Eisdorfer (1965). The writer is further indebted to Drs. Altrocchi and Eisdorfer, and to the *Community Mental Health Journal* for granting permission to quote from this paper.

have similar professional training and/or work for the same community agency. At each meeting, a member of the consultee group reports a problem case on which he (or she) is currently working. Consultees are asked to present cases that are likely to be of general interest to other group members. They are further encouraged to select cases in which there is believed to be good potential for client improvement which may be facilitated through successful professional engagement. However, those who volunteer to present cases are given complete freedom in the final selection of the case. In working with the same groups over a period of time, we have observed that the cases presented generally represent a good cross-section of those seen by the agency or professional group.

Prior to the group meeting, the consultant arranges to discuss the case with the reporting professional. Aspects of the case which might not be appropriately brought up for discussion in the case-seminar are considered at this time. Whenever practicable, the consultant obtains first-hand contact with the client, either by interviewing the client or observing him interact with the consultee. We have found that clients are generally receptive to being interviewed by the consultant and regard the consultee's arranging the interview as an indication of his interest in them. The consultant's interaction with the client is typically supportive and often surprisingly therapeutic in its impact. Actual contact with the client makes it possible for the consultant to bring to bear the full range of his professional skills in evaluating the case for teaching purposes and also serves as a precautionary safeguard against missing crucial diagnostic information (e.g., suicidal or homicidal tendencies) which may not be evident to the consultee. In addition, conferring with the client in the consultee's presence permits the consultant to demonstrate interviewing techniques that may be employed by the consultee in working with other clients.

In case-seminar meetings, the etiology and dynamics of the client's problems are discussed in relatively nontechnical terms. The responsibility of group members for maintaining the confidentiality of all matters considered in these meetings is strongly emphasized. Relations between the client and the consultee, and between each of them and other persons involved in the case (e.g., the client's family and other professional workers), are considered in detail. The complex roles and functions of the group consultant who utilizes the case-seminar method have been described by Altrocchi, Spielberger, & Eisdorfer (1965) as follows:

> The mental health consultant who uses the case-seminar approach must function simultaneously in several different roles: teacher, group leader, clinician and facilitator of communication between community groups. As a teacher, the consultant does not necessarily attempt to transmit specialized technical knowledge; but he does convey general principles and knowledge about those techniques which can be used within the range of the consultee's particular professional background. In this capacity, the consultant may function as a seminar leader, a

resource person, and a lecturer; the specific techniques will naturally depend upon his own professional background as well as the qualifications, experiences, and needs of the consultee group. In early sessions formal lecturing on personality development and psychopathology, as well as suggestions on interviewing technique, are often appropriate. In later sessions he is more apt to function as a resource person and seminar leader. In the leader sessions it is particularly important that the consultant be careful to clarify the limits of his ability to resolve questions raised by the consultees and to dispel any omniscience or omnipotence which may be imputed to him. Since the consultant's primary goal is to help the group and the individual consultees to learn to be able to derive meaningful solutions for work problems on their own, he should gratify demands for him to provide solutions only enough to keep the consultation sessions from becoming unduly frustrating to the consultees.

As a group leader the consultant acts as a catalyst to stimulate members of the group to share experiences and to explore together the problems of their clients, and helps to clarify problems, focus discussion, and conceptualize solutions suggested by consultees. In the roles of group leader and teacher, we have also found it useful to relate the case under discussion to our own clinical experience and to expose to the group our own limitations and continuing efforts to broaden our understanding of human problems. Such personal reflection typically fosters identification with the consultant and emphasizes his humanness and lack of omniscience and omnipotence (Berlin, 1962). . . .

The mental health consultant's role as group leader often merges with his role as a clinician, especially during the discussion of the feelings of a consultee toward a client. Considerable clinical sensitivity may be required in deciding when to slow down or, instead, to deal directly with affective expression by a consultee. However, we do not concur with Caplan (1964) that the consultant should consistently avoid any direct discussion of the consultee's feelings and should interrupt such discussions if they arise spontaneously in a consultation group. Members of professional groups are not as fragile as patients and therefore do not require the same degree of protection, given the existing protection of the work-group setting. We do draw the line when aspects of the historical development of the consultee's personal feelings enter the discussion. On rare occasions, a brief excursion into a consultee's personal problems may be deemed appropriate because of the centrality of the problem to the role of the particular professional group. Such invasions of the consultee's private life should only be pursued if the consultee has the requisite strength to deal with his problems, commands the respect of the group, and provides the initiative for discussing his personal problems as "a case at point."

As a clinician, the consultant must always be prepared to use his clinical skills and his knowledge of referral resources and procedures in cases of client emergencies. The consultant's experience and ability as a clinician is a particular asset when consultees are interested in "practical approaches" and not merely theoretical approaches to their problems.

Finally, an additional important role of the consultant becomes clear in his interaction with different community agencies. Case presentations often reveal the frustrations of consultees who must work with personnel from other agencies. Complaints range from individual ineptitude on the part of other professionals to red tape, gross obstructionism, and glory seeking. On more than one occasion, workers from two agencies competing for the management of a client presented the same case in their respective seminar groups. This presents the mental health consultant with an ideal opportunity for facilitating inter-agency communication by helping members of different professional groups to appreciate the role of other professionals. Thus the mental health consultant who works with groups on a community-wide basis has the role of a facilitator of communication between various community caretakers and the professional groups they represent (pp. 131-132).

During a productive group mental health consultation session, four phases may generally be observed: an introductory phase, a warming-up phase, a problem-focused phase, and an ending phase (Kevin, 1963).[3] In the introductory phase, the reporting professional presents background data and current information about the case, and the consultant describes his interview with the client. Feedback and follow-up information on cases previously discussed may also be brought up at the beginning of the session. The warming-up phase generally consists of the elaboration and clarification of information presented in the introductory phase in response to questions from members of the consultee group. In the problem-focused phase, the etiology and dynamics of the client's problems are formulated, taking special note of the client's strengths and resources as well as of his shortcomings and limitations. Alternative approaches to the case are then proposed by group members in the context of a realistic appraisal of community resources. In the ending phase, the collective experience of the group is brought to bear on the merits of these alternatives, and one or more specific courses of action is suggested by the group to the reporting professional for exploration. A brief discussion of arrangements for the next case-seminar meeting usually concludes the session.

Striking differences may be observed in mental health consultation with different professional groups, and from session to session with the same group. Differences in group process and in the rapidity with which the group proceeds from one phase of consultation to the next appear to be related to the professional training and experience of group members, group morale and cohesiveness, and specific factors associated with the case that is being discussed. Groups with strong cohesiveness and high morale may move rapidly into the problem-focused phase, where they work creatively in formulating solutions to vexing questions raised by the case under consideration. In contrast, the consultation process may never move beyond the introductory or warm-up phases in groups that are simply collections of professionals with similar jobs.

---

[3] Kazanjian, Stein, and Weinberg (1962) have used similar terms to conceptualize phases they have observed in individual consultation. They describe individual consultation as consisting of the following: preparatory phase, beginning phase, problem-solving phase, and termination.

In working with the same group of consultees over a period of time, the cumulative impact of group mental health consultation is clearly reflected in the cases that are selected for presentation and in the manner in which each case is presented. Bizarre or "impossible" cases are often presented in the early stages of group consultation (Rieman, 1963). For such cases, one important facet of the consultant's role is helping consultees to understand and accept the fact that, in working with clients who are not likely to benefit from their services, the investment of inordinate amounts of time is unwarranted. In the later stages of consultation, experienced members of consultee groups tend to select cases for presentation that are more representative of those seen by the group as a whole and thus more useful for generating fruitful discussions. Greater sensitivity to mental health problems and a more sophisticated understanding of these problems are also generally reflected in the presentation of these cases.

The productivity of a mental health consultation group will depend, in large measure, on the degree to which the consultant is successful in fostering the development of a group atmosphere that is supportive and nonjudgmental, that stimulates group members to share work experiences and professional problems. Sharing experiences establishes a basis for meaningful communication which permits group members to bring to bear the full range of their collective experience in solving the specific problems raised by the case being considered. The sharing of problems is particularly important for group problem solving in that this tends to reduce the consultee's feelings of isolation, professional inadequacy, and anxiety. Consultees who initially volunteer to present cases are also usually more ready to share their personal reactions to their own clients and to offer constructive comments on cases presented by their colleagues. While the contributions of these group members are most helpful in moving the group into the problem-focused phase, the consultant must resist the temptation to move ahead with them until he perceives that a majority of the group is ready to do so.

There is, as yet, little objective evidence of the effectiveness of mental health consultation with groups. However, in regard to many aspects of the group consultation process there is considerable agreement among those who have compiled and recorded their observations (e.g., Altrocchi, et al., 1965; Berlin, 1962; Kevin, 1963; Maddux, 1953; Parker, 1958; Rieman, 1963). It has been observed consistently that the sensitivity of members of consultee groups to the dynamics of interpersonal relations is greatly enhanced, as reflected in improved relationships between consultees and their clients. Group mental health consultation also generally improves group cohesiveness and group morale and tends to facilitate communication among group members and between community agencies. In addition, the consultee who gains a better understanding of the reactions common to his professional group is helped to achieve greater insight into his own conflicts and personality dynamics and how these may influence his work (Parker, 1962).

While agreement among those who have engaged in group mental health consultation is impressive, there is need for a more objective confirmation of these observations and impressions. Research is required to determine the impact of group consultation on the skills and attitudes of members of various key professional groups as well as on the effectiveness of these professionals in working with their clients. We need to know much more about such things as the optimal length and frequency of group sessions, the dynamics of the group consultation process, and the personal qualities and technical skills that contribute to making mental health professionals effective as group consultants.

THE MENTAL HEALTH CONSULTATION PROGRAM IN WILMINGTON

The mental health consultation program in Wilmington evolved within the context of the programs of the Association for Mental Health and the Health Department and was greatly influenced by the public health traditions and community education orientation of the sponsoring organizations. Mental health consultation was initiated with public health nurses, ministers, and caseworkers on the staff of the Department of Public Welfare. The significant contributions of these professional groups as community caretakers was self-evident; frequent requests from individual group members for assistance with cases involving the mental and emotional problems of their clients attested to their interest in receiving consultation and their potential for contributing to community mental health. In conferences with agency officials and with officers of the ministerial association, approval was given for scheduling continuing case-seminars with each of these groups on a monthly basis.

An office for the mental health consultation program was established within the Health Department, and a staff public health nurse was appointed as the coordinator of the program. The nurse-coordinator organized the consultant's schedule and arranged for him to meet with professionals who were presenting cases, and with their clients. She also scheduled conferences and interviews with community leaders and professionals requesting consultation, handled all requests for mental health services, and maintained the program records and files.

On the recommendation of the consultant, a planning committee was established to serve as a policy-making board for the consultation program. This committee, called the Mental Health Program Planning Committee, was appointed by the sponsoring organizations and consisted of representatives of the Association for Mental Health, the Health Department, and other community agencies and professional groups. When the consultant's time in the community was increased to two days per month, a monthly meeting with the

Planning Committee was scheduled as a regular part of the consultation program.

The members of the Planning Committee represented an excellent cross-section of the lay and professional leadership of the community and provided the consultation program with sensitive and realistic perceptions of the community's mental health needs. The Planning Committee not only provided guidance and advice but also served the very important function of interpreting the mental health consultation program to the community. The collective wisdom, community insight, and constructive actions of the Planning Committee, more than any other factor, contributed to the growth and development of the mental health consultation program.[4]

One of the first tasks to be tackled by the Planning Committee was to determine how the consultant's additional time in the community might best be utilized. It was generally agreed that the long-term mental health interests of the community could be best served by concentrating on problems involving children, and that the single institution through which children with mental health problems could be reached most effectively was the public school system. Therefore, it was decided that conferences would be held with school officials to determine the feasibility of extending the mental health consultation program into the schools. On the basis of these conferences, case-seminars were initiated with elementary school teachers and high school guidance counselors. Arrangements were also made for individual consultation on a time-available basis with school administrative officials, principals, and teachers.

There were many more requests for consultation and clinical services in Wilmington than could be honored. There were also a number of groups in the community to whom we wished to offer consultation who did not request it. This state of affairs led to intensive discussions of program priorities and to the articulation of a concept that we have called *ethical choice*. This implies a method of working out priorities for program development on the basis of (1) value judgments concerning significant areas of community mental health need, and (2) realistic appraisals of the "readiness" of specific professional groups or community agencies to benefit from consultation at a given point in time. The professional skills and limitations of the consultant must, of course, also figure prominently in the equation for determining program priorities. Thus, the decision to extend the mental health consultation program into the schools was based upon the Planning Committee's judgment that promoting the mental health of school children was a high priority community goal, the expressed readiness of school officials to permit and facilitate the establishment of appropriate consultation groups, and the consultant's discernment that he could work effectively with these groups.

---

[4] The writer is indebted to many citizens of Wilmington and New Hanover County for their contributions to the Mental Health Consultation Program, and particularly to Dr. C. B. Davis, Miss Elizabeth Watling, Miss A. Lou Davis, and Mrs. Betty West of the Health Department; Mrs. Herbert Bleutenthal, Mrs. Bea Lounsbury, Miss Kathryn Noyes, Mrs. Alice Sisson, and Mrs. Francis Walker of the Mental Health Association; Mr. T. O. Page, Mrs. Ethel Booth, and Mr. Fred Capps of the New Hanover County Schools; Rev. John Irwin and Rev. Richard Johnson of the Ministerial Association; Mrs. Helen Sneeden, New Hanover County Department of Public Welfare; Mrs. Emma Howell, Family Service Society; and Mr. J. M. Hall, Jr., Chairman, Board of County Commissioners.

The concept of ethical choice was also useful as a guide in selecting the particular groups or units within an institution to whom consultation would be first offered. For example, it was necessary on one occasion to decide with which of two schools a consulting relationship would be established. There was only time enough to work with one of these schools. From all available data, School A, located in a deteriorating lower-class neighborhood, appeared to have a larger proportion of children with severe mental health problems than School B, which was located in an attractive middle-class suburb. The area served by School A had a higher incidence of crime, mental hospital admissions, delinquency, and broken homes than the area served by School B. While it was generally agreed that mental health consultation was more urgently needed in School A than in School B, the principal of School A did not feel that consultation would help him solve his school's problems. Rather, he wanted to refer disturbed children for treatment. In contrast, the principal of School B had repeatedly requested consultation and was quite receptive to exploring various ways in which the consultant's limited time—about two hours per month—could be used most effectively. On the basis of perceived differences in readiness in these two schools, the establishment of a consultation relationship with School B seemed to make the best use of the consultant's time. As things turned out, it was also eventually possible to establish a consulting relationship with School A; and this was facilitated by having demonstrated the value of consultation under more optimal circumstances in School B.

During the more than four years in which consultation visits were made to Wilmington on a regular basis, there were requests for assistance from a variety of sources. At first, these came primarily from professionals at the grass roots level, including individual members of consultee groups, and physicians, lawyers, probation officers, directors of religious education, nursery school teachers, Family Service workers, and many others who worked directly with people. After the consultant had worked in the community for several years, there were more frequent opportunities to confer with community leaders on a variety of topics with important mental health implications, and particularly with members of the boards that established policies for the professional groups with whom the case-seminars were conducted. There were also more opportunities to consult with top agency executives such as the Superintendent of Schools, the Directors of the Health and Welfare departments, and elected officials of the city and county government.

In the summers, when schools were not in session and the case-seminar with the ministerial group was not held, a series of conferences were held with administrative employees of the Public Housing Authority. The consultant also explored the possibility of developing mental health activities within local industrial settings in conferences with personnel directors, production managers, and industrial health workers. Among the concrete results of these exploratory activities were (1) the participation of several industrial nurses in the case-seminar with public health nurses, and (2) the convening of a conference with the Board of the Public Housing Authority. In the latter the mental health implications of prevailing policies governing the acceptance of applicants for low-rent housing were discussed, and questions relating to general management policies were considered. The meeting with Housing Authority Board members also served to point up a number of important personal qualifications that Housing Authority employees should have, in addition to their technical skills, if they are to work effectively with tenants.

A schematic diagram of the mental health consultation program in Wilmington as it was organized during its third year is presented in Figure 1. Limitations in the consultant's time prevented further development of the program until the fourth year, in which a full-time psychologist was added to the staff of the Health Department. This made it possible to establish consultation relationships with additional groups in the schools and to expand the time available for consultation with individual professional and community leaders. As soon as arrangements could be made to obtain the part-time services of a qualified psychiatrist, it was also possible to offer limited direct services to individuals who were referred to the Health Department. While the mental health consultation program continued to place special emphasis on prevention of mental illness and community education, it was not long before funds were appropriated that permitted the establishment of a fully staffed mental health center.

CASE-SEMINARS WITH SPECIFIC PROFESSIONAL GROUPS

The case-seminars with public health nurses, ministers, welfare caseworkers, and public school personnel met continuously over a period of several years. General characteristics of the mental health consultation process observed to be common to these groups have already been described. Some aspects of the case consultation process which seemed to be more specific to individual professional groups will now be discussed.

Case-Seminar with Public Health Nurses

The case-seminar with public health nurses was conducted during the working day as a part of the in-service training program of this group. The responsibilities of public health nurses require them to care for all of the health needs of their patients, and they have neither the time nor the training

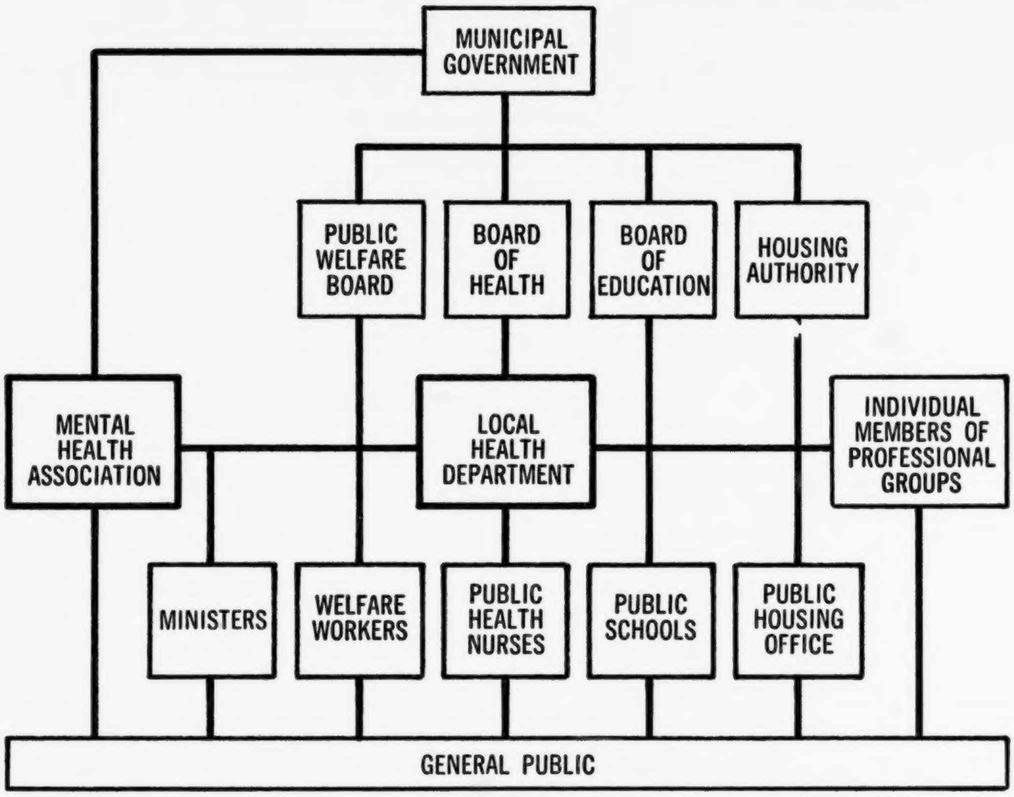

MUNICIPAL GOVERNMENT
PUBLIC WELFARE BOARD
BOARD OF HEALTH
BOARD OF EDUCATION
HOUSING AUTHORITY
MENTAL HEALTH ASSOCIATION
LOCAL HEALTH DEPARTMENT
INDIVIDUAL MEMBERS OF PROFESSIONAL GROUPS
MINISTERS
WELFARE WORKERS
PUBLIC HEALTH NURSES
PUBLIC SCHOOLS
PUBLIC HOUSING OFFICE
GENERAL PUBLIC

Figure 1. The administrative organization of the community mental health consultation program in Wilmington and New Hanover County, North Carolina, as it functioned during its third year as an integral part of the programs of the Health Department and the Mental Health Association. A staff public health nurse was assigned as program coordinator, and representatives of the Association for Mental Health, the Health Department, and other community agencies served as the policy-making board. The mental health specialist spent two days each month in the community providing group consultation for public health nurses, ministers, Department of Public Welfare caseworkers, elementary school teachers, and school guidance counselors. The consultant also worked with Public Housing officials and with the executives and boards that set policies for the agencies with whom group consultation was conducted. In addition, individual consultation was provided, on a time available basis, for members of the consultee groups and other professional workers.

for full-scale mental health rehabilitation work. But public health nurses can be more effective in their jobs if they have a more basic and broader understanding of the whole patient. Furthermore, given the high regard in which she is held by her patients and the trust that characterizes the attitudes of patients toward her, the public health nurse is in a unique position to do preventive mental health work.

The content of the case-seminar with public health nurses was oriented toward the many ways in which the nurse could intervene appropriately in order to promote the mental health of her patients and their families. In a number of cases this involved making referrals to other agencies such as the Family Service Society and the Welfare Department and helping the patients to establish relationships with these agencies. In others, the nurse assisted seriously disturbed patients in arranging voluntary commitment to state mental hospitals before a complete mental breakdown occurred. Through their work in maternity clinics and well-baby clinics, conducted at the Health Department and in public housing developments, nurses had many opportunities to work with patients whose major problems stemmed from emotional rather than physical causes. Case-seminar discussions of these cases focused upon the potential impact of the nurse on child-rearing patterns and on attitudinal problems that had to be overcome in order to assist the patient in obtaining available health services for themselves and their children.

Most of the nurses were assigned as school nurse to one or more public schools. Therefore, in keeping with our decision to concentrate on problems involving children, the activities of the public health nurse in the schools were the focal point of the consultant's work with this group. Accordingly, the didactic content of a number of case-seminars was concerned with the intellectual and personality development of children and with the use of symptoms to satisfy emotional needs. Most cases on which nurses conferred with teachers about school children involved some aspect of the child's physical health. However, in a substantial proportion of the cases referred to the school nurse, the mental health problems of the children were paramount; and such cases were often presented in the case-seminar. Whenever possible, the child's teacher and the school principal were invited to attend the seminar and to contribute information based on their personal observations.

On several occasions, it was decided that it might be helpful for the nurse to visit the child's parents. She was often in a better position than the teacher to do this because the attitudes of parents toward nurses are generally positive, whereas their attitudes toward their children's teachers are often ambivalent. The nurse-teacher relationship and the liaison role of the nurse in helping to work out a better relationship between teachers and parents represented a meaningful extension of the nurses' professional role which seemed to have important mental health implications.

Case-Seminar with Ministers

The cases discussed with this group included parishioners and their families who sought assistance from their ministers for a variety of reasons, e.g., vocational adjustment, marital difficulties, child-rearing problems, alcoholism, and not infrequently, psychotic conditions. The ministers as a group were particularly interested in gaining a better understanding of the personality problems and emotional needs of their parishioners, and in how the minister could assist parishioners in dealing with life situations complicated by emotional conflicts. They were also highly sensitive to their limitations in working with severely disturbed parishioners and very much concerned with ascertaining procedures for making referrals of such parishioners for psychiatric treatment.

A number of sessions with this group were devoted to considering techniques that could be employed by ministers in pastoral counseling with parishioners who came to them with specific kinds of problems. For example, in four successive cases, presented by different ministers and considered over a six-month period, we concentrated on problems related to alcoholism. Some of the substantive issues that were discussed included: (1) alcoholism as a symptom of emotional disturbance, (2) the effects of alcoholism upon family relationships, (3) the minister's personal attitudes toward the use of alcohol and how these attitudes complicated his working with parishioners with drinking problems. It became apparent that, in general, the minister's role in pastoral counseling is considerably more complex than that of a mental health specialist in psychotherapy, especially if the parishioner is an active member of his congregation. In addition to counseling with parishioners, the minister must address them from the pulpit and make numerous other demands on them within the context of the total church program. Perhaps the most difficult problem that confronts the minister in his pastoral counseling role is keeping his other roles from intruding upon it, and this was frequently the subject of lively discussion in the case-seminar sessions.

In working with clergymen, the consultant was initially concerned with how to approach conflicts that might arise between theological and psychological principles. However, these concerns proved groundless. Differences between the theological views of ministers from different religious denominations were vastly greater than any that arose between the convictions of individual ministers and the psychological principles of the consultant. On those occasions when apparent conflicts between theology and psychology were brought out, after further discussion, the difficulties were easily resolved. For example, in a discussion of the development of conscience, one minister took strong exception to the consultant's psychoanalytically oriented description of the effects of early experience on the formation of the superego components—the conscience and the ego-ideal. The minister insisted instead on the theological principle that "conscience was God-given." After pondering the apparent conflict between these theological and psychological views of conscience, the group came to the conclusion that while the *potential* for conscience might be God-given, helping people to develop this potential was a proper task for clergyman and psychologist alike!

Case-Seminar with Welfare Caseworkers

The cases discussed with Department of Public Welfare (DPW) caseworkers included problems such as foster home placement, situations involving dependent children, and clients who were permanently and totally disabled. Almost all of the DPW clients, by legal requirement, belonged to the lower social classes; and poverty was a ubiquitous problem. Since a sizable proportion of the DPW clients were Negroes, discussion with DPW caseworkers frequently centered around difficulties that are experienced by Caucasian middle-class professionals in working with predominantly lower-class clients from other racial groups. In some cases, the comments of the Negro caseworkers were particularly meaningful to their colleagues in helping them to understand the problems associated with minority group status; but even here, class bias was apparent. Much discussion was required to help the caseworkers understand and handle their feelings of anger and disgust which often erupted when they were called upon to help clients whose morals and behavior were so different from their own.

There is little doubt that a substantial percentage of the clients served by DPW caseworkers would have received psychiatric diagnoses had they been seen at a mental health clinic (Maddux, 1950). Yet most of the caseworkers had little or no training in working with individuals with serious emotional problems. A considerable amount of time in case-seminar meetings was therefore given to providing didactic information about personality and psychopathology. Discussions of the significance of parent-child relationships in determining adult personality patterns, especially the patterns of hostility and dependency that so often characterized DPW clients, helped caseworkers to understand why they were frequently the targets of hostility from clients whom they tried so hard to help. Such discussions also helped them to develop relationships that fostered greater independence in their clients.

The significance of treating all clients with dignity in order to help them develop and maintain self-respect was emphasized with DPW caseworkers, as was the philosophy of "helping the client to help himself." It was evident, however, that the large caseloads carried by members of this group made it almost impossible for them to devote enough time to any single case to have much beneficial impact. Therefore, one of the major goals of the case-seminar was to help the caseworker differentiate among clients according to their rehabilitation potential so that relatively more time could be spent with those who might benefit most. This required recognition and acceptance of the unfortunate reality that, in many cases, there was little that anyone could do to help the client.

Consultation in the Public Schools

The mental health program within the schools was initially limited to the consultant's work with public health nurses in their roles as school nurses. Whenever a nurse selected a case involving a school child for presentation to the case-seminar, prior permission was obtained from the child's parents, his teacher, and the school principal; the teacher and principal were also invited to attend the case-conference. This procedure brought the consultant into direct contact with school personnel and provided an opportunity for discussing mental health problems with them. Subsequently, when additional consultation time in the community became available, there was considerable enthusiasm for setting up more formally structured consultation activities within the public schools.

The first seminars to be established were with elementary school teachers and high school guidance counselors.[5] The case-seminar with elementary school teachers was coordinated by the supervisor of elementary education. This group met in the evenings, and the teachers who attended did so on a voluntary basis. Teachers were encouraged to bring up "mental health" problems from their own classroom experiences, with mental health defined in very broad terms. For example, it was suggested that students with superior ability who did not live up to their academic potential might have significant mental health problems even though they did not exhibit overt symptoms of behavorial disturbance. Topics brought up by teachers included: (1) difficulties in dealing with children who use attention-getting mechanisms in the classroom, (2) techniques and procedures that teachers can use in the classroom for assisting children with emotional problems, (3) the teacher as a person with emotional needs of her own, (4) underachievement as an indication of mental health problems, (5) questions concerning the IQ grading system which served as the major basis for the assignment of children to particular class sections.

A regular case-seminar with high school guidance counselors developed out of the consultant's evaluation of a student who was referred to him by the director of the Family Service Society. This case involved Robert, an eleventh-grade pupil who planned to withdraw from school prior to his senior year to take a job. Robert had performed extremely poorly in the past, was failing most of his present subjects, and was drifting toward delinquency in his behavior at school and in the community. Most of Robert's teachers felt that he had very limited ability; and this opinion was supported (or perhaps largely determined) by his IQ test scores, which ranged from 60 to 74 on three different administrations of the Otis Group Intelligence Test. However, one teacher was convinced that Robert had the ability to do better work than was indicated by his past performance, and this teacher requested help from Family Service in arranging to have Robert tested.

The consultant agreed to evaluate Robert provided that a meeting could be arranged with his teachers to review the test findings with them. In addition to Robert's teachers, the high school guidance counselors, including teachers who served as part-time counselors, were also invited to this meeting. The psychological examination revealed that Robert had high-average to bright-normal intellectual *potential* that was not reflected in his school performance because of a severe reading defect. This reading disability obviously detracted from Robert's performance on the group intelligence tests which were heavily weighted with verbal and reading skills. Personality tests further indicated that Robert perceived himself as extremely limited, reflecting the opinion of his teachers—and no doubt of his peers as well—that he was "mentally retarded." This self-perception disposed Robert to believe that he lacked the ability to do school work and caused him to give up quickly on any task that required more than minimal mental effort. His low self-esteem in school-related activities also led him to seek acceptance from peers by engaging in antisocial gang behavior.

---

[5] For an excellent discussion of the roles and functions of the mental health specialist as a consultant in the schools, see Berlin (1956, 1962).

On the basis of the discussion of Robert's problems in the conference with teachers and counselors, arrangements were made for him to receive special remedial reading instruction during the summer; and a program was outlined for his senior year that took account of his reading deficiency. With Robert's permission, a conference was also held with his parents, with whom our information was shared. It was recommended that Robert be allowed to attend school in the fall, at least until the Christmas recess; his parents agreed to this. Robert continued with remedial reading during his senior year, and his teachers were alerted to his reading difficulty. With special help and encouragement, Robert graduated from high school; and achievement tests indicated he had made outstanding progress in his senior year. In a follow-up of this case three years later, it was learned that Robert had married, was continuing to make excellent progress in a responsible job, and was regarded by his employer and others in the community as a good citizen.

An important feature of the case-conference with high school guidance counselors was the selection and scheduling of students to be seen by the consultant. Members of the group proposed students whom they felt might profit from talking with the consultant about their school difficulties. The problems of these students were then discussed by the group, and a decision was made as to which students would be invited to meet with the consultant. In an effort to avoid placing undue pressure upon students, the teacher-counselor carefully explained that: (1) the purpose of the interview was to help the student; (2) the subjects discussed would be kept confidential; (3) the student's participation was completely voluntary. The fact that over a third of the students who were invited to meet with the consultant declined to do so suggests that the teacher-counselors were at least moderately successful in structuring the situation as "voluntary."

Significant changes in behavior were observed in students who indicated that they were willing to talk with the consultant, and these generally occurred *before the interview ever took place.* It appeared that a sympathetic confrontation of the student with his problem behavior by a teacher-counselor who offered help had a salutary effect on the student's behavior. Such changes were probably facilitated by the development of more constructive attitudes in the teacher-counselor and by her direct expression of personal interest in helping the student to solve his problem. An important lesson to be learned here is that minimal intervention can often result in beneficial behavioral change in persons whose problems are not yet deeply ingrained.

TRAINING ASPECTS OF THE CONSULTATION PROGRAM

The mental health consultation program in Wilmington contributed to the in-service training of public health nurses and Department of Public Welfare caseworkers, and it served an important training function for ministers, school personnel, and members of other professional groups who received consultation. This program was also utilized by the Department of Psychology at Duke University as a part of its training program for graduate students in clinical psychology. Initially, students who accompanied the consultant on his visits to the community did so on an irregular and informal basis. Later, students who were enrolled in the writer's Advanced Clinical Seminar regularly accompanied him on consultation visits to the community.

The students sat in on group consultation sessions as participant observers and accompanied public health nurses, ministers, and welfare caseworkers on visits to their clients. As a course requirement, students were required to write detailed reports of their observations. In addition, each student wrote a term paper on some aspect of the consultation program, relating their observations to the general literature on group dynamics, clinical psychology, social psychology, etc. The students' reactions in this limited exposure to mental health consultation were most enthusiastic, and their observations and experiences in the community served to provide needed perspective for their clinical work. From the consultant's point of view, the observations, reactions, and enthusiasm for the program of the students who accompanied him were invaluable.

CONSULTATION AS AN APPROACH TO COMMUNITY MENTAL HEALTH PROBLEMS

Over a decade ago, in an address to the Stanford Conference on Psychology and Mental Health, Robert H. Felix, then Director of the National Institute of Mental Health, took cognizance of prevailing manpower shortages in the mental health disciplines. Felix (1957) noted that it would be unlikely that our nation could ever produce enough therapists to handle all the psychological problems of all people on a treatment basis. Consequently, he suggested that mental health specialists become concerned with facilitating the contributions of other professions and community agencies in the promotion of mental health and the prevention of mental illness. At the same meeting, in a similar vein, Carter (1957) posed the following question: "Shall we commit our limited and expensive professional resources to the treatment of only a few of the many seriously disturbed individuals in the community or shall we give more emphasis to preventive services and to serving large numbers of people?" (p. 25).

Our current answer to Carter's question is reflected in the results of a survey of 595 mental health clinics by Norman, Rosen, and Bahn (1961). Their findings indicated that in 1958 only about 6% of the professional man-hours in these clinics was used for community services. For the median clinic, the percentage of professional time invested in community services was 4.2 with three-fourths of the clinics reporting that either no time or less than 10% of their scheduled professional man-hours were used for indirect services or direct preventive functions. In a follow-up report to the Surgeon General's Ad Hoc Committee on Mental Health Activities (1962), Bahn indicated that little change had been noted in the amount of time that clinic professional personnel were devoting to community services. Thus, despite serious shortages in trained mental health personnel and growing awareness that the mental health contributions of other professions and community agencies could be enhanced if they were given more assistance by mental health specialists, the major time commitment of mental health professionals continues to be in direct services to patients.

With the publication several years ago of *Action for Mental Health* by the Joint Commission on Mental Illness and Health (1961), there has been notable and significant reexamination of present efforts to meet the mental health needs of the nation. However, in the recommendations of the Joint Commission a serious admitted bias in favor of direct services to the mentally ill is revealed; and this may account, in part, for the reluctance of mental health specialists to engage in community services. The report states:

> We shall emphasize various dimensions of service to troubled persons and to mental patients. We must not repeat the mistake, made in the 1909 founding of the National Committee for Mental Hygiene, of diverting attention to the more appealing and stimulating but as yet visionary prospect of true, or primary prevention of mental illness (p. 241). . . . We have assumed that the mental hygiene movement has diverted attention from the core problem of major mental illness. It is our purpose to redirect attention to the possibilities of improving the mental health of the mentally ill (p. 242).

Does the Joint Commission's emphasis on direct services to mental health patients provide a realistic approach to meeting community mental health needs? In commenting on this aspect of the report, Stubbs (1963) points out that helping the "sick" to recover is only half the job and that it may be even more important to help the total population achieve an optimal level of "emotional well-being." Stubbs recommends that we deploy our limited mental health manpower resources in balanced programs that focus on psychological growth and the development of creative potential as well as on psychopathology. The Surgeon General's Ad Hoc Committee on Mental Health Activities (1962) has also recommended that community mental health programs place greater emphasis on indirect services such as consultation and in-service training to other agency personnel. If we are to begin to meet community mental health needs, the mental health specialist must spend as much time in working with people who deal with people as he does in working directly with disturbed persons.

INDIVIDUAL AND GROUP CONSULTATION

As an approach to community mental health problems, consultation with key professional groups and community leaders represents an important and essential component of a balanced mental health program. Consultation with members of professional groups helps them assist their clients to function more effectively and productively in solving problems and resolving emotional conflicts before they reach a degree of severity that requires the attention of a mental health specialist. It also greatly enhances the quality and the timing of referrals from the community caretaker to the mental health specialist.

Group consultation is more efficient than consultation with individuals in that it allows the mental health specialist to reach a larger number of professionals during a given period of time and permits the individual group member to absorb information and raise questions that are relevant to his particular level of professional development. Group consultation also facilitates exchange of information and sharing of experiences, often stimulating considerable spontaneous interaction among group members on cases other than those discussed in group meetings. Consultation with individual professionals is more adaptable than group consultation for responding to consultee-client crises and more appropriate for working with insecure consultees who may be unwilling to share work problems with their peers. Individual consultation also permits more candid discussion of sensitive case materials and makes it easier for the consultee to bring up personal matters that may have important bearing on the case. The case-seminar method has provided a meaningful combination of group and individual consultation for the professional groups with whom we have worked. In group sessions, consultees become familiar with the professional competence of the consultant and learn to trust him. Subsequently, an individual consultee may seek help on a problem that he might feel reluctant to discuss in the group. As a result of this individual consultation, the consultee generally becomes more comfortable in sharing his work-related problems with the group.

The mental health consultant who works with a number of professional groups and community agencies can do a great deal to facilitate interagency understanding and cooperation. By arranging for a professional worker from one agency to participate in a group consultation session with another agency, the consultant can help to bring about a more comprehensive understanding of cases on which there is multiple agency involvement. The visiting professional, in describing his involvement on the case, helps to clarify the nature of the services offered by his agency and how these services are performed. The resulting clarification of professional roles and functions permits a more optimal utilization of community resources.

CONSULTATION WITH COMMUNITY LEADERS

Since economic, social, and cultural factors are critical determinants of emotional disturbance and well-being, consultation with community leaders is essential in a balanced and comprehensive mental health program. Effective community action for mental health requires community involvement and community control as well as continuity of concern for the troubled individual (Smith & Hobbs, 1966). The separation of mental health services from other community institutions is a major barrier to effective programming which can be surmounted only if responsible representatives of the community are actively involved in program development. Citizens and community leaders must therefore share responsibility with mental health specialists in the planning of community programs.

The early and continued participation of community leaders in program planning is essential to meeting the mental health needs of the people, and these needs can be optimally served by integrating mental health services with other community programs (Lamson, 1955). The active involvement of citizens in mental health programs through organizations such as the National Association for Mental Health is neither "visionary" nor a diversion of attention as suggested by the Joint Commission. Such involvement is mandatory, for it provides the perspective that is required to develop a mental health program befitting the needs, customs, and resources of the community.

REFERENCES

Albee, G. W. *Mental health manpower trends.* New York: Basic Books, 1959.

Altrocchi, J., Spielberger, C. D., & Eisdorfer, C. Mental health consultation with groups. *Comm. Ment. Health J.*, 1965, *1*, 127-134.

Berlin, I. N. Some learning experiences as psychiatric consultant in the schools. *Ment. Hygiene*, 1956, *40*, 215-236.

Berlin, I. N. Mental health consultation in schools as a means of communicating mental health principles. *J. Amer. Acad. Child Psychiat.*, 1962, *1* 671-679.

Bindman, A. J. Mental health consultation: Theory and practice. *J. consult. Psychol.*, 1959, 23, 473-482.

Caplan, G. *Principles of preventive psychiatry*. New York: Basic Books, 1964.

Carter, J. W. The training needs of psychologists in community mental health programs at state and local levels. In C. R. Strother (Ed.), *Psychology and mental health*. Washington, D.C.: Amer. Psychol. Ass'n., 1957. Pp. 21-40.

Felix, R. H. The role of psychology in the mental health effort. In C. R. Strother (Ed.), *Psychology and mental health*. Washington, D.C.: Amer. Psychol. Ass'n., 1957, Pp. 4-20.

Joint Commission on Mental Illness and Health. *Action for mental health*. New York: Basic Books, 1961.

Kazanjian, V., Stein, S., & Weinberg, W. L. An introduction to mental health consultation. *Public Health Monograph No. 69*, Washington, D.C.: GPO, 1962.

Kevin, D. Use of the group method in consultation. In L. Rapoport (Ed.), *Consultation in social work practice*. New York: Nat'l. Ass'n. of Social Workers, 1963, Pp. 69-84.

Lamson, W. C. Integrating mental health services into the community health and welfare program. *J. Psychiat. Soc. Work*, 1955, 24, 243-249.

Libo, L. M., & Griffith, C. R. Developing mental health programs in areas lacking professional facilities: The community consultant approach in New Mexico. *Comm. Ment. Health J.*, 1966, 2, 163-169.

Maddux, J. F. Psychiatric consultation in a public welfare agency. *Amer. J. Orthopsychiat.*, 1950, 20, 754-764.

Maddux, J. F. Psychiatric consultation in a rural setting. *Amer. J. Orthopsychiat.*, 1953, 23, 775-784.

Norman, V. B., Rosen, B. M., & Bahn, A. K. Community oriented services of psychiatric clinics, 1958. *Public Health Reports*, 1961, 76, 231-237.

Parker, B. Psychiatric consultation for nonpsychiatric professional workers. *Public Health Monograph No.* 53. Washington, D.C.: U.S. Dept. of H.E.W., 1958.

Parker, B. Some observations on psychiatric consultation with nursery school teachers. *Ment. Hygiene*, 1962, *46*, 559-566.

Report of the Surgeon General's Ad Hoc Committee. *Mental health activities and the development of comprehensive health programs in the community*. Washington, D.C.: GPO, 1962.

Rieman, D. W. Group mental health consultation with Public Health Nurses. In L. Rapoport (Ed.), *Consultation in social work practice*. New York: Nat'l. Ass'n. of Social Workers, 1963. Pp. 85-98.

Smith, M. B., & Hobbs, N. The community and the community mental health center. *Amer. Psychol.*, 1966, *21*, 499-509.

Stubbs, T. H. The risk of false promise in achieving public emotional well-being. *Alabama Mental Health*, 1963, *15*, 3-6.

IV

NEW APPROACHES IN THE SCHOOLS

13

PREVENTIVE ASPECTS OF SCHOOL EXPERIENCE[1]

Herbert Zimiles
Bank Street College of Education

THE SCHOOL AS A PSYCHOLOGICAL INFLUENCE

A result of current interest in preventive mental health phenomena is that the school has become a focus for both primary and secondary prevention programs. The reasons for this emphasis on the school are not complicated. It is axiomatic that efforts at prevention should begin early in the life of the individual, since intervention geared to helping the school-age child is likely to be more effective than that concerned with the adult, who is less receptive to change. Moreover, working in the school has the advantage of the fact that it is one of the most influential institutional agents in the community, unique in its access to all strata of society. For the most part, prevention programs in the school have focused on the early identification of emotional disturbance, on prompt and appropriate referral, and occasionally, on a treatment regimen itself. Usually, the school is selected as the setting for such work because it has children available and because it provides the necessary facilities and institutional leverage.

The concept of a *school as a place* where children live rather than as a place where they are kept or trained is not easily learned. Even sophisticated social scientists concerned with preventive mental health issues appear to view the school principally as a repository for the children whose future mental health they are dedicated to protect. Although school mental health programs often differ from other forms of public health involvement in that they are not totally divorced from the educational operation—unlike the alien dental clinic standing amid the classrooms of children, a mental health program will often recruit teachers to help identify the most disturbed and vulnerable children on the basis of their classroom experience with them—the participation of the teacher is usually seen as marking a departure from her customary role. If the mental health worker sees a connection between his own concerns and those of the teacher, it is that the child's extra-learning behavior prevents his integration into the classroom routine and impairs his ability to learn. The classroom proper, with all its children, is seldom taken to be the province of a mental health prevention program, even though it constitutes an environment in which the child will live during his formative years and in which he will undergo experiences that will shape his ultimate psychological structure.

---

[1] Thanks are due to Jacqueline Rosen and Doris Wallace for their thoughtful review of this manuscript.

A contrasting viewpoint, growing out of modern educational theory, assigns to the school a much more active role in preventive mental health. Schooling is seen as a primary form of psychological intervention; it serves as an agent for promoting psychological growth, for mediating cognitive-affective integrations which support effective functioning and personal fulfillment. To describe the school as an agent does not imply that the school has an active choice to make as to whether it will have psychological impact. From a dynamic viewpoint, schools must inevitably have profound and widespread psychological influence. The psychological influence of schools varies according to their expressed goals, but also according to characteristics about which they may have only limited awareness. They produce both intended and unintended outcomes. Only when the classroom and the school are regarded as psychological fields, and the implications of all transactions occurring within these fields are made explicit, can proper evaluation of an educational program be made. While most modern educators are interested in broadening and reformulating educational programs and objectives, it is one of their main contentions that the scope of influence of existing school programs is already much greater than is generally recognized, that life in school impinges on virtually all other facets of the child's existence.

The overall psychological impact, as distinguished from the less inclusive, purely academic-intellectual impact of school experience, is often viewed as an unintended side effect because educators, like most of us, prefer to formulate the goals of their enterprises in very concrete terms. This is one reason why acquisition of knowledge has traditionally been used to assess educational growth. More complex effects than those assessed by conventional achievement tests are usually relegated to the amorphous status of unpredictable and intangible consequences. The complexity of these "side effects" is compounded by their being very different for different children. Nevertheless, it is maintained that these more nebulous, interactive aspects of school experience are more significant in the long run. The way in which school reinforces or alters psychological growth, the way it combines with other influence processes to change their path of action, has greater implications for the future development of the child than the acquisition of discrete skills solely attributable to the school.

Another factor which discourages interest in the psychological influence of school experience is the long-standing tradition of limited emotional investment in school affairs. Teachers often define their role as narrowly as possible, restricting themselves to the dissemination of knowledge according to the specifications of curriculum bulletins. The children, in turn, respond by developing a stylized reaction to school characterized by overt compliance but limited emotional commitment. Just as men are capable of isolating several years of their lives in the armed forces in order to disconnect the experience from the basic directions and purpose of their lives, so, too, can children learn to "tune out" experiences in the school, thus minimizing their impact. However, because the child is not fully integrated in his psychological functioning during these formative years, the effectiveness of his psychological withdrawal from the classroom is reduced. Such withdrawal is not without psychological significance; the idea that the child thereby creates a psychological vacuum is, of course, an illusion. If the primary mood of the school is disinterest or uninvolvement, this, too, becomes a potent psychological influence.

An analysis of the psychological implications of classroom events and the formulation of a set of coordinate educational objectives has been a major contribution of the work of Barbara Biber (1955, 1961). Among the potential consequences of school experience, cited by her, is the opportunity it can offer for extending the child's feeling of acceptance to an orbit beyond his immediate family. The primitive, early childhood relationships with the family forge a concept of self and outer world which becomes solidified by the regularity of the family-dominated environment of early childhood. Upon entering school, the world of the child is expanded, elaborated, and reordered. What he experiences in school can serve to confirm and validate what he has already learned at home, or it can offer a set of alternatives which permit him to view his already established relationships and perceptions from a new, substantial perspective. The impact of a school program, however, does not have an invariant effect on all those exposed to it, since the effects of the child's new experiences in school are governed by the character of his psychic organization, by his ability to assimilate novelty and modify previous perceptions and cognitive orientation on the basis of new experience.

No realistic appraisal of the influence of school experience would ascribe to it those psychological forces which have been set in motion and sustained by the home. What is customarily regarded as the characterological core of the child's psychological make-up owes its formation to the nuclear relationships within the family. Nevertheless, the child begins to attend school early enough for some of these more basic psychological structures to be affected. From one standpoint at least, one might speculate that the school's psychological impact will be stronger than that of the home. Early experiences and relationships have so decisive an effect on the development of perception and values that the home environment may form the background against which extrafamilial figures in the contemporaneous world are sorted and responded to by the child. In contrast to the fixed perceptions derived from family life, the variation in school life provided by transitions from year to year in teacher and class composition introduces enough novelty to permit the school to maintain a compelling quality as figure against the ground of the home.

In sum, these arguments challenge the idea that school impact can be restricted to academic or specific psychological dimensions according to the will of the teacher. What transpires in the classroom can be examined through different lenses. The affective and the intellectual are different modes of classifying aspects of the psychological processes which inhere in all classroom behavior. Whatever the style of teaching and quality of classroom life, they can be studied in relation to their implications for the psychological influence on the participating children, according to whichever variables interest the observer. The emphasis here is on the totality of factors and their interrelations which operate in the classroom, on an educational program based upon a sociopsychological analysis of the classroom situation.

It should be noted that the point of view summarized in the preceding paragraphs does not imply an unqualified endorsement of recent secondary approaches to mental health in the schools. While such preventive programs tend to increase the psychological awareness of school personnel, they exert a conservative influence upon education by helping emotionally disturbed and other groups of children to respond effectively to already established patterns of teaching. A psychological viewpoint should pervade the total planning of the school program, and not be confined to coping with isolated problems such as the identification of pathology. Special services within a school should emanate from a master plan based upon an analysis of the needs of children from the standpoint of developmental theory (Biber & Franklin, 1967).

These same reservations apply to crash programs now directed at disadvantaged children. Preventive mental health in the school is too universal and too complex a task to be studied by *ad hoc* groups expecting short-term breakthroughs. It would appear that these efforts would be better spent if they were directed toward achieving a more pervasive and enduring influence. Furthermore, children who are manifestly ineffective in school may constitute the most serious problem; but they are outnumbered by the masses of children who go through school unnoticed yet who have not truly learned or experienced gratification from learning, who have been exposed to a school environment that reinforces their acceptance of anonymity and marginal effectiveness.

A STUDY OF SCHOOL EFFECTS AT BANK STREET COLLEGE[2]

At Bank Street College, where there has been a long-standing commitment to modern educational theory based on years of practice and observation in the schools, it was decided to put some of these empirically-based convictions to a more systematic and rigorous test. We wanted to determine whether children really are affected by schooling in the ways we had come to believe and to explore other possible dimensions of school influence. Consequently the Research Division undertook an intensive study of children who attended different kinds of schools. Countless facets of the school environment merit systematic study as independent variables in the analysis of the psychological effects of school experience. Among these, we chose a molar variable, the modern-traditional continuum of school ideology and practice. By traditional ideology we meant an approach to education which emphasizes intellectual achievement along predetermined lines and demands rapid socialization; modern ideology was defined as assigning greater value to individuality and to the *processes* of thinking and learning than to the mastery of specified content. The modern-traditional quality of a school environment was judged to embody its most salient influencing factors. The modern-traditional concept provided a framework for describing how diverse educational considerations were organized and integrated to achieve a variety of interrelated educational goals. We concluded that schools, explicitly or implicitly, organized their programming on the basis of a constellation of ideas which occupied different points on the modern-traditional continuum. The continuum became our independent variable.

---

[2] This research project, "The Psychological Impact of School Experience," was supported by a grant from the National Institute of Mental Health (M 1075). The com-

This stance required us to define what we meant by modern and traditional educational ideology and practice and to devise criteria for judging schools and child-rearing practices along this dimension. It was surprising how difficult this was to accomplish and how compromised some staff members felt when the ultimate definitions and criteria to be used were established. Multiple criteria were established, thereby raising questions regarding their hierarchy and the nature of their interaction. If criterion A is present in a school but not criterion B, is A of the same quality when it is accompanied by B? It was also recognized that in using multiple criteria, we could never be sure which components of the configuration of antecedents were more or less responsible for the effects we observed.

The basic strategy of the study was to find groups of children of essentially equivalent socioeconomic background who attended schools which varied along the modern-traditional continuum, and then to subject these children to intensive individual psychological study along a set of selected dimensions in order to explore psychologically meaningful variables, rather than mere indices of academic achievement. Practical considerations dictated that the intensive assessment of the children (which was to extend over six different individual interview and testing sessions, covering a total of eight

---

plete results of this study will be reported in a forthcoming book by the senior investigators, Patricia Minuchin, Barbara Biber, Edna Shapiro, and Herbert Zimiles, to be published by Basic Books, Inc. in 1968. The selected findings reported in this article are the result of the collective efforts of a great many members of the Research Division at Bank Street College of Education, but responsibility for the interpretation of the findings presented here rests solely with the author.

or nine hours) be restricted to a relatively small number of subjects. In all, 105 fourth graders constituted the subject group.

Four different schools, each representing different points on the modern-traditional continuum, were chosen. Although it would have been less complicated to include only public schools in the study, our wish to have the most modern end of the continuum represented required the inclusion of an independent private school. The four schools from which fourth-grade children were selected for intensive study, therefore, consisted of three public schools, two of which were considered quite traditional and the other modern, and a very modern, independent private school. The series of comprehensive and rather complex criteria established to characterize whether a school was modern or traditional, which guided the selection of schools, included judgments of: the role of the school in educating for competence; the relation of the school as an institution to its social and professional milieu; the quality of personal interaction among children and school staff and within the hierarchical structure; the school's view of individuality; and the manner in which it deals with issues of motivation, autonomy, and self-realization.

An obvious methodological barrier to the study of the effects of variations in school experience is the problem of controlling for sources of influence other than the school—most prominently the influence of the home. Two methods of control over the influence of the home, both approximate, were employed. The groups were equated with regard to certain home variables—the children were selected so that the four groups were essentially equivalent as to the socioeducational-economic character of the home, so that variation among the groups in the dependent variables could not be attributed to variation in these characteristics. In addition, each of the mothers of the study children was interviewed and completed a questionnaire regarding child-rearing ideology. The degree of correlation between the measures of child-rearing practices and ideology and attributes of the children's psychological functioning was recorded to establish the relation between home characteristics and the dependent variables. In this manner differences in dependent variable measures found among school groups could be examined in the light of information regarding the relative contribution of home influence. This mode of control was neither complete nor precise but offered an estimate of the relative impact of the most competitive source of psychological influence—the home.

In planning the assessment procedures, it became apparent that our expectations regarding the school's influence on the child did not necessarily involve variables for which psychologists had developed methods of measurement. The antecedent conditions we studied were not of the type routinely manipulated by experimenters; they constituted a large segment of the child's environment, the effects of which had not been studied previously. In addition, our mental health framework forced us to break out of the circle of conventional research variables, so that some new conceptualizations and methods were created. For example, we were interested in such variables as the quality of self-differentiation present in these children—the degree of articulation of their awareness of themselves as people. We were also interested in their relative commitment to childhood as opposed to adulthood, in the nature of their investment in childhood, in how involved they were in anticipating and rehearsing adult roles and values.

Along similar lines, our interest in studying the effects of variation in school experience upon cognitive development reminded us that cognition had been very narrowly defined by psychologists in terms of existing experimental measurement procedures. Both methods and concepts relating to this psychological process, so basic to education, were disappointingly limited. Consequently, the results of our investigation of this sphere of functioning were extremely uneven. Marked variation among the groups, as well as a unique patterning of abilities within a group, were found in an area of cognitive functioning for which measurement was highly refined, whereas differences between the groups often failed to appear in those spheres which were not so well developed methodologically.

In this relatively brief chapter, it is not possible to summarize all of the results of the study of the children. The variables which were assessed ranged from attitudes toward school to aspects of cognitive style, patterns of self-perception and feeling, and interpersonal perception and relatedness. The presentation of findings will be restricted to a single dimension cited previously—the child's orientation toward childhood.

How he views childhood was considered to be one facet of the child's relatedness to the self, and the issue of self-perception was regarded as pivotal in assessing the effects of school experience. It can be argued that the issues of individuality and self-enhancement lie at the core of the philosophical conflict between modern and traditional theories of education. They appear in a variety of contexts, impinging on questions of impulse control, character building, and the way in which learning occurs in depth. One of the hallmarks of traditional education is its fundamental concern with the development of "self-control" in the yet undisciplined school-age child. The school is seen as helping the child to subjugate his inner thoughts, feelings, and impulses in order to facilitate his moral development and clear the path for knowledge.

The modern educator, on the other hand, marks personal experience as the starting point of learning. He focuses more on the hypothetical process of ego-enhancement and the achievement of mastery and competence. Consequently the self constitutes the prime mediator of the learning process.

The utilization of play and dramatization as a medium for learning as well as for emotional expression, along with the accepting atmosphere of the modern school and the deliberate attempt to use the child's own childlike experiences and interests as a resource for directing the path of learning, are in contrast with the traditional school's central concern with socialization, with facilitating and hastening growth toward adulthood, often accompanied by the stigmatization of childishness and childhood. This would tend to suggest that the child's perspective with regard to child-adult status would be differentially affected by school experience. A number of measures bearing upon this issue were obtained, both direct and indirect, most of which tend to substantiate this expectation.

In the course of the interview and testing sessions, the child was asked what age he believed to be best, what he thought was the best job in the world, and what he would do with a million dollars if it were given him to spend in one day. His responses to these questions, and the stories he made up to a set of pictures, were rated according to their adult-child quality—according to whether the jobs chosen and the modes of spending the million dollars adhered to adult patterns and images of work and wealth or typified the child's orientation to money and jobs and were concerned with fulfilling more child-like impulses.

There were reliable differences among the school groups in their responses to the question about the best age to be. The modern private school group consistently favored earlier life stages, showing a greater affinity for childhood and their current age level. The rank order of the mean preferred age corresponded exactly to the rank order of the degree of traditionalism in the four schools.[3]

The remaining findings of this cluster present a more consistent pattern. The responses given to the Children's Picture Story Test, a variant of the TAT, were rated according to the degree to which they involved themes relating to older social sex roles such as dating, marriage, and having children. Here, once again, the rank order of mean ratings paralleled the rank order of traditionalism. The magnitude of the differences among schools did not achieve statistically significant levels.

In a similar vein, the traditional school groups more often described adult-oriented jobs as those they considered best. These included engineer, lawyer, doctor, housewife, teacher. Their conception of the desirable job was clearly modeled upon adult standards. By age nine their ideas about what constituted desirable work were hardly distinguishable from those offered by adults. In contrast, the modern school group's responses—for example, fireman, detective, ballet dancer—were reliably more fantasy-derived and more closely associated with the facets of life in which they were most deeply interested. Their choices were clearly more child-centered.

Responses to the million dollars dilemma followed the same pattern. The traditional school group more often gave adultlike responses. They thought of buying property, of making huge investments and acquiring companies. They were much more concerned with the accoutrements of wealth as adults tend to see them. The modern private school again was much more preoccupied with securing pleasures associated with childhood, with buying toys, finding opportunities to visit places, and obtaining entertainment they longed for. They were less systematic and businesslike in their way of disposing of so large a sum of money; their responses were more childlike. The rank order of group means corresponded perfectly with the traditionalism rank order of the groups. The overall difference among school means was reliable, as was the difference between the modern private school mean and that of each of the two traditional school means.

---

[3] It should be noted, however, that in this instance, data obtained from a self-rating procedure concerned with a very similar issue failed to reliably differentiate the four school groups. The difference in results between the two sets of data is probably attributable to the wording of each of the procedures.

In these instances, then, a relatively consistent pattern of differentiation among the school groups was obtained. It is important to note that the modern private school group, found to be more identified with childhood, was not simply more childlike. The usual constellation of characteristics associated with immaturity were not present in these children. There was no evidence that they felt more helpless or less responsible as human beings. In this regard, their fantasy productions contained fewer references to adult figures; apparently there was less need to include parent figures in the events they portrayed in fantasy. In addition, when parent figures were included, they portrayed them with less veneration than did children from the traditional schools. Other evidence indicated that the ties to the home were just as strong in these nine-year-old children; the difference between the two groups lay in the content of their fantasy, in the prominence of parent figures and their supportive quality.

Additional data of interest came from a series of questions about crime and punishment in which the children were asked to indicate what they thought was the worst crime. Here there was virtual unanimity; almost all the children responded with murder or some equally heinous act. But when they were asked to indicate what was the worst thing that a child in their class could do, most of the children from the public school groups usually mentioned some form of childish prank. A substantial number from the modern private school group, however, responded once again with murder. This difference in response can be interpreted in various ways. When examined in conjunction with the previously cited results, it appears to express the children's differing perception of their own power and influence. The public school children learned to view their childhood state as a form of preadulthood or apprenticeship, a state of being with limited privileges and power, whereas those from the modern private school saw childhood as having a status of its own and children as possessing potential power and destruction not unlike adults.

These findings are presented as illustrative of the level of analysis employed and the modes of differentiation obtained in our comprehensive study. As one dependent variable after another was studied with regard to school effects, one of the most prominent patterns of findings to emerge was the difference between boys and girls, irrespective of school. For example, striking sex differences were found among the measures of identification with childhood cited above. In response to the question about the best age, the girls reliably more often favored older stages—adolescence and adulthood—whereas the boys preferred their present age or slightly younger. The differences among the school groups in their tendency to include themes relating to older social sex roles on the Children's Picture Story Test were primarily accounted for by the higher mean scores found among the traditional school girls. Significant sex differences in each of the two traditional schools, as well as in the total sample, were found.

Statistically significant differences between the sexes were found among many of the other variables which were studied—imaginativeness, the degree and quality of self-differentiation, the tendency to introduce parent figures into fantasy productions, the mode in which aggressive feelings were expressed in fantasy, and the manner in which the self was projected in figure drawings. There were differences, too, in how popular and competent the boys and the girls believed themselves to be in relation to the rest of their class and in how convinced they were that it was better to be a member of their own sex. The rediscovery of sex differences is a major theme among the findings of current research in developmental psychology. The sex difference results of greatest interest in our study were those which interacted with school differences (Minuchin, 1965). Such patterns occurred with sufficient reliability and regularity to conclude that some of the schools which were studied reinforced the psychological divergence among the sexes more than others, and that questions regarding the responsiveness to school environments needed to be studied separately for each sex.

CONCLUSIONS AND IMPLICATIONS FOR FUTURE RESEARCH

Although the findings reported here pertain to only a fragment of the variables which were studied, it is apparent that a great deal of additional work is needed to clarify the issues raised by our work. More dimensions of personality and cognitive functioning need to be investigated and the sample broadened to include children from more diverse socioeconomic backgrounds. Perhaps most important, the effects of school experience should be studied at several points in development, spanning the period from the beginning to the end of school. Clearly the impact of schooling evolves over time; it is a developmental process. The residue of each component of school experience interacts with future school experiences and developmental changes. School programming, when planned with deliberation and foresight, takes the current developmental needs of the child into account and utilizes these trends in shaping a program that will maximally foster growth according to ultimate goals. If we think of the child's school career as a journey, comparisons of school effects at any single point in time are useful and illuminating but reveal only landmarks. Variation among the schools in pacing—how much time is taken initially for priming the participants or planning the entire trip, whether they have chosen to traverse some of the more difficult terrain earlier or later—makes it difficult to forecast the ultimate outcome on the basis of the school group's relative position at some intermediate point.

One fault of the above analogy is that it suggests that contrasting educational ideologies offer alternative paths to a single destination. The differences found between the modern and traditional school children with respect to their investment in childhood and their involvement in later stages of development strongly suggest that different developmental processes were involved, that these schools were cultivating different patterns of child growth in order to achieve overlapping but different objectives. The differing objectives of contrasting educational programs is an issue which warrants more intensive thought than it usually receives. We often oversimplify controversies over ideology by stating that they are concerned with different means to achieve a common end. Yet the hierarchy of values inherent in the modern and traditional ideologies is clearly distinct; the repertoire of behaviors they value most highly in the functioning adult are far from identical. Overlapping value systems with distinct hierarchical structures are as different from one another as a patron of the arts is from an artist. When the time comes that educators can specify and implement their goals with great precision, the problem of conflicting values between the educational practitioner and client will have to be confronted.

Where our findings have been negative, they have led to the customary reevaluation of theory and method. But the complexity of our research problem is such that even our positive findings have an enigmatic quality. For example, striking differences were found in the children's attitude toward school, which confirmed our expectations. The data indicated something many educators have long known—that school can be made attractive and even lovable. And it is accurate to say that many of the children who were studied, particularly those from the modern schools, really loved school. It satisfied their thirst for inquiry and supported development of competence along personally selected and meaningful lines. However, the self-evident desirability of these outcomes should not cause us to lose sight of the purposes which more customary attitudes of hostility toward school may have served. The very durability of traditional education would suggest that something about its form renders it dynamically functional, that its particular approach serves adaptive ends. Considered from this standpoint, the congeniality of the relationship between child and school effected in the modern school raises questions we have not had an opportunity to study. Does the customary animosity toward school have some special function in the child's psychic economy? For example, to what extent does the school serve as the object of displaced hostility toward the parents, as a kind of safety valve in the parent-child relationship? Are there some advantages, as well as the self-evident disadvantages, associated with a limited commitment to school? How does investment in school affect other primary relationships? These questions remind us that the child's relatedness to school is part of a dynamic network; they introduce still other perspectives to the study of school influence.

In a number of instances, this study has contributed new formulations of dimensions of personality and cognition. The child's investment in childhood and his degree of involvement in later stages of development have been shown to be significantly affected by school experience. Other findings, not presented in this chapter, have pointed to the significance of the dimension of group functioning, at a cognitive as well as social level. Our work also confirmed that relatively fine distinctions in personality functioning, such as degrees of self-differentiation, can be assessed and, further, can be shown to be related to particular forms of school experience. Among the most unexpected and interesting findings were those relating differential school experience to the sex of the children. It would appear that some educational theorists have been so concerned with overcoming arbitrary and restrictive attitudes which differentiate the activities and interest patterns of boys and girls that they have lost sight of important developmental and psychological differences between the sexes which affect the meaning and influence of school.

It scarcely needs to be noted that our findings have not demonstrated that thoughtful planning and execution of school programs can prevent mental illness. Disabling pathology usually involves factors outside the realm influenced by school experience. However, when the psychological organization of the child is more plastic, when it is not rigidified by pathology, the findings indicate that significant dimensions of psychological functioning can be influenced by the character of school environment. Since, obviously, the modern-traditional quality is not the school's only dimension of variation, and since the study itself should properly be regarded as only a pilot version of the evaluation of this modern-traditional continuum, it may be suggested that the influences of school experience are far more extensive and complex than our study has revealed.

The relevance of this work to the preventive mental health movement lies as much in its form as in its substantive findings. It is rare for behavioral scientists to have the opportunity to study the effects of so profound a difference in stable, enduring conditions of life—environmental factors which are at the same time completely malleable, which can be shaped by man's will. If preventive work is to advance beyond the point of exclusive concern with the early identification and treatment of pathology, if it is to contribute to social planning by gauging and manipulating psychosocial environments, then it must embark upon a similar course of study. It must first identify the dominant influence systems in the environment and then systematically assess the effects of variation along its most salient continua. Such work is destined to proceed slowly because it requires far more refined analytic procedures for dealing with simultaneous multiple influence factors and their interaction than now exist. In the final analysis, however, such work is essential if the social sciences are to become more potent instruments for inquiry and the mental health movement is to approach its goal of effective prevention.

REFERENCES

Biber, B. Schooling as an influence in developing healthy personality. In R. Kotinsky & H. L. Witmer (Eds.), *Community programs for mental health*. Cambridge, Mass.: Harvard, 1955. Pp. 158-221.

Biber, B. Integration of mental health principles in the school setting. In G. Caplan (Ed.), *Prevention of mental disorders in children*. New York: Basic Books, 1961. Pp. 323-352.

Biber, B., & Franklin, M. The relevance of developmental and psychodynamic concepts to the education of the pre-school child. *J. child Psychiat.*, 1967, *6*, 5-24.

Minuchin, P. Sex-role concepts and sex typing in childhood as a function of school and home environments. *Child Develpm.*, 1965, *36*, 1033-1048.

14

PRIMARY PREVENTION IN THE CLASSROOM THROUGH A TEACHING PROGRAM IN THE BEHAVIORAL SCIENCES[1]

Sheldon R. Roen

Teachers College, Columbia University

Schools present a most compelling avenue for preventive programs since they are institutionalized settings in which all children can be found. Programs of mental hygiene in classrooms have been advocated for many years (Group for the Advancement of Psychiatry, 1951). The bulk of these programs, however, have not met with adequate success. Among the reasons for this are the following: some programs required special training of scarce personnel; others asked for the enthusiastic cooperation of overtaxed, disinterested, and professionally reluctant teachers and administrators; and still others were so lacking in appeal or validity as to appear solely an exercise in moralizing.

PRIMARY PREVENTION IN THE CLASSROOM

Primary prevention aims at reducing the incidence of disturbance. It is not always necessary to know the exact cause of a disturbance in order to make some gains in preventing it from occurring. Improvement programs based on educated guesses of the relationship between variables have often realized positive results. For example, even before the existence of germs was known, the observation that cleanliness, sanitation, and pleasant living conditions relate to the maintenance of physical health was sufficient to carry forth effective public health programs. In the economic realm, where determination of etiology is also frustrated by complexities, the recent bold stroke of reducing taxes so as to increase consumer spending seems to have maintained the period of prosperity. Currently, the approach to general problems of social well-being in the United States suggests that concerted action on plausible notions is the order of the day.

Although behavior has long been regarded as a function of a person and an environment, fascination with internal machinations of deeply embedded dynamics has led to concentrated attention on psychotherapeutic treatment. The influence of psychoanalytic theory, because of its individual approach, delayed serious consideration of preventive programs. The new interest of mental health professionals in the interaction of people with their environments has restimulated thoughts about prevention.

---

[1] The teaching program represents a project carried out at the South Shore Mental Health Center, Quincy, Massachusetts, where the author was Director of Research.

In essence, primary prevention either fortifies the risk group in such a manner as to enable it to ward off affliction or rearranges an environment so as to expel the harmful features. It follows that the earlier this can be accomplished in a life cycle, the greater the opportunity for lowering incidence of disturbance. Thus, many programs of primary prevention tend to focus on parents and on schools.

In considering what can be done to help school children cope more effectively with life stresses, an optimal approach would be directed to both the child and his school environment. At a practical level, however, it is helpful to focus on one or the other of these alternatives. With regard to the school environment, the assumption is made that the conditions surrounding the educational process have the power to mold. The teacher's attitude, outlook, and relationships with her pupils are each prime ingredients of this environment. Additionally, the social structure of the school and the classroom, and the very manner in which education goes about its business, are important components. If, on the other hand, the child himself is to be directly fortified, consideration should be given to the more formal learning inputs. Attention would then be focused on curriculum content, and on the specific learnings and values inherent in a particular curriculum.

TWO SUSTAINED APPROACHES

There have been several attempts to come to grips with issues of mental health and the classroom. The history of past efforts includes a large-scale activity program in the New York City schools (Loftus, 1940, 1943), human relations classes in the junior high schools (Bullis, 1941), development of materials and approaches to improve intergroup understanding (Taba, 1949), and the training of selected teachers and school administrators to enable them to guide discussions of human relations in the classroom (Seeley, 1954). Critical elaboration of these projects is not necessarily germane to the purposes of this chapter. However, two programs sustained for over twenty-five years, each reflecting a different prong of primary prevention strategy, stand out as guideposts.

The Total School Atmosphere Emphasis

The first sustained program to be discussed stems from the work of Barbara Biber and the Bank Street College group. Their method, which evolved from Dewey's concepts of learning and social interaction, advocates "infusing mental health principles in every school process" (Biber, 1961, p. 348). Based on a multiple criterion approach, which integrates the goals of education and the goals of mental health, their program emphasizes the positive relations of children with teachers and administrators, cooperative relations among the staff, flexibility of curriculum and evaluation, and the cordiality of the teaching process.

They see an inescapable circularity in the intricate interdependence of cognitive and affective growth (Cartwright & Biber, 1965). Although mastery and achievement are recognized as essential to ego strength, they feel that the experiences and relationships through which cognitive learning functions are also prime factors. Their teacher education methods (Biber, Gilkerson, & Winsor, 1959) are based on general propositions which serve the purposes of mental health; they are useful in understanding psychological constancies in the educational process. The following interlocking goals (Biber, 1961) have been formulated: (1) positive feeling toward self, (2) realistic perception of self and others, (3) relatedness to people, (4) relatedness to environment, (5) independence, (6) curiosity and creativity, and (7) recovery and coping strength.

There is obvious difficulty in conducting research on the formulation developed by the Bank Street College group, but a critical study of the assumption that the quality of school experience significantly effects the total psychological growth of children has been undertaken by them (Biber, 1961). The research design calls for the examination of 106 fourth graders, matched for IQ, in four different schools. The schools were selected in terms of significant differences along the modern-traditional continuum. Some general results of this study are presented by Zimiles in Chapter 13.

The Improved Curriculum Emphasis

Since 1941, Ojemann (1961) and his colleagues at the University of Iowa have conducted a conscientious research and development program on teaching children a causal orientation to the social environment. This causal orientation was defined by Ojemann as an understanding and appreciation of the dynamic, complex, and interacting nature of the forces that operate in human behavior; it involves an attitude of flexibility, of seeing things from the viewpoint of others, and an awareness of the probabilistic nature of knowledge. Their approach assumes that a person who is aware of the dynamics and causal nature of human activities is better able to solve his own problems and to deal with social situations.

The Iowa project involves no specific intent to introduce new subject matter, as such, into the school curriculum. Rather, the intent is to restructure the existing curriculum (social studies, English, geography, etc.) so that it attends to issues of human behavior. Intensive teacher training programs were developed (Stiles, 1950) to foster a causal orientation among teachers so that their pupils would benefit from early and sytematic exposure to this mode of thinking. For Ojemann (1959) "the essential problem is to devise a curriculum that is causally oriented throughout and that is taught by a causally oriented teacher beginning in the early years" (p. 21).

Various studies from the Iowa Child Welfare Research Station have shown their work to be effective. Muuss (1960) matched three groups of 25 sixth graders on IQ and sex. One group participated in the program for one year, another group for two years, and the third group did not participate at all. Criterion measures included the Problem Situation Test (a measure of the tendency to use immediate punitiveness), the Children's Anti-democratic Scale (CADS), and certainty scores of a test for intolerance of ambiguity. The group exposed to the program for two years showed a significantly positive gain over the one-year group on these measures. Levitt (1955) showed in a previous study that experimental subjects, exposed to the causal teaching program, had become significantly less authoritarian and more willing to assume responsibility. Stiles (1950) investigated changes in the method used by fourth-, fifth-, and sixth-grade children to handle daily behavior situations brought up for consideration in the "Room Council." He found that the causal learning program produced significant changes in the direction of decreased punitiveness; the children were more concerned with understanding before deciding. Ojemann, Levitt, Lyle, and Whiteside (1955) trained teachers to use special curriculum methods emphasizing multideterminism. The teachers were trained for one month in the summer, and group conferences were held every three weeks during the year. Experimental teachers were matched with control teachers, who made use of materials if they so desired but were not trained to use them. The results showed that classes belonging to the experimental teachers showed a marked positive change in punitiveness and causal orientation. In a more recent study (Ojemann & Snider, 1964), a causally oriented behavior observation form was used by trained observers. Results showed significant gains in causally oriented behavior by the experimental groups.

A somewhat different curriculum approach has been conducted by Lippitt, Lippitt, and Fox (1964) at the Institute of Social Research at the University of Michigan. They formulated a pilot project to explore the possibilities of early social science education and developed and taught six social science laboratory units, including learning from grownups, feedback in interpersonal relations, and rules and standards in group life. These units were planned to fit flexibly into current social studies programs.

Discussion

The Bank Street College approach involves, by its very nature, an espousal of a value system. It is allied to the "social-political liberalism of the century, or more generally, the values of the humanist point of view" (Biber, 1961, p. 325). Personality is to be engineered, so to speak, on the basis of a congruence between mental health values and the goals of modern education through the medium of interacting factors in school life. The assumption is that an emotionally "healthy" experience with the process of learning will aid in developing a child's ego strength.

While there is a compelling logic to this point of view, the values underlying the program are not held by all. Some believe such specifications about personality are not in the realm of the educational mandate and interfere with the child's or family's spontaneous finding of their own most comfortable level of contribution, unencumbered by homogeneity of perceived values. Society, it is agreed, is better for having the fragile, exquisitely sensitive person as well as the brash promoter. Although elements of the Bank Street College program have had an influence on school procedures in general, acceptance has not been widespread; its greatest influence has been in selected private school settings.

The improved curriculum approach as represented by Ojemann and his co-workers has had even less impact on school procedures. In part this may be due to the fact that the program requires that the teachers be motivated to seek training. Good teachers do, in fact, often supplement the prescribed curriculum with current events or interests stemming from their own background and experiences, but such supplements do not generally require extended knowledge about the materials being considered. The "causal orientation" would seem to be not only an attitude of mind but also a serious subject for study and mastery by the teacher. Since specific allotments of time are not set aside for this aspect of the curriculum, but rather the orientation is interlaced through units already being taught, it requires considerable organizational ingenuity in order to incorporate it effectively into a teaching program.

The Ojemann program is also hampered by the way teacher education institutions organize their training programs. Courses are usually taken along subject matter lines, and things psychological are taught peripherally as foundation subjects. If this model were to change so as to articulate better the purposes of a truly integrated curriculum, greater success with the causally oriented curriculum might be realized. However, the trend appears to be in the opposite direction; the times advocate an even higher degree of specialization and a commitment to specific skills and subject matter. Educators may be more likely to accept the teaching of an entirely new discipline, replete with its own curriculum materials, methods, and trained teachers, than to rework old, established ways of doing things. The "new" mathematics and science curricula were brought into forward-looking school systems *in toto*, rather than as piecemeal revisions of existing approaches.

THE BEHAVIORAL SCIENCES CURRICULUM IN THE ELEMENTARY GRADES

Since 1963 an experimental program of teaching the behavioral sciences as a formal, academic, curriculum subject has been conducted in selected elementary schools located in the South Shore area just outside of Boston. Sponsored by the South Shore Mental Health Center, this program was initially begun as an extension to the school mental health consultation program that has been in effect for over a decade. The teaching program has gone through several stages of development since it was first instituted. In the subsequent sections of this chapter an attempt will be made to describe the program's rationale, its history, its application to fourth-grade classes, and its subsequent extension into residential treatment. Furthermore, a controlled evaluation of the effectiveness of the program, and the development of a seminar for teachers, which has grown out of it, will be described.

HISTORY OF THE PROJECT

The impact of Sputnik on American education resulted in a movement toward revision of elementary school curricula in the areas of natural science and mathematics. At the time, this type of curriculum revision seemed an appropriate reaction. However, with the advent of the frightening prospect of holocaust due to an inability to settle the question of atomic testing, it became increasingly clear to some that humanity was less in need of scientific preeminence than of solutions to its behavioral problems. Competition for technical superiority seemed almost beside the point when consideration was given the unsolved problems of human behavior as reflected in disordered international relationships.

At about this time, also, there appeared a resurgence of interest in preventive mental health programs stimulated by the publication of the final report of the Joint Commission on Mental Illness and Health (1961). Drawing on the author's previous attempt to foster mental health in the classroom by teaching "behavioral science" units to public school children in New York City's Harlem (Rosenthal, 1952), and contemplating the meager progress achieved by advocates of mental health programs in the schools, it seemed timely to think about a broad conceptualization of the school's role in both mental health and behavioral studies. Such a conceptual framework needed to encompass the current philosophy of education, incorporate the salient concerns of contemporary life, and serve the purposes of primary prevention in the field of mental health. The conceptualization that emerged was the teaching of the behavioral sciences as a formal, academic subject in the elementary schools.

Bruner's (1961) influential essay *The Process of Education* seemed to lend support to this approach. In the assertion that "any subject can be taught effectively in some intellectually honest form to any child at any age of development" (Bruner, 1961, p. 33), one finds a basis for upgrading the traditional elementary school curriculum in subjects such as algebra, science, economics, and foreign languages (Gross, 1964), as well as for the creation of curricula in the heretofore unexplored behavioral science areas. Bruner (1965) himself has developed an anthropological course of study for grade school children in which the content is man. Currently designed for fifth graders, his curriculum is organized around approaches to three questions: What is human about human beings? . . . How did they get that way? . . . and, How can they be made more so? This mode of curriculum revision is congruent with, and can well serve as a part of, a broader curriculum in the behavioral sciences extending from first grade, if not kindergarten, through the remainder of public school education.

RATIONALE

Supporting arguments for introducing the behavioral sciences as a school subject in the primary grades can be advanced from various perspectives. A detailed discussion of such a program's rationale from an educational point of view has been presented elsewhere (Roen, 1966, 1967b). The main educational argument holds that psychology, sociology, and anthropology have come of age as scientific and professional disciplines; they have become so much a part of contemporary culture that those who have not been exposed to their subject matter are considered lacking. These disciplines, together with elements of psychiatry, economics, political science, and demography, might also serve as a structure to bridge the estrangement between the humanities and the sciences so well described by C. P. Snow. The behavioral sciences, although they, too, are plagued by camps who hold different value systems, are rooted in both objective and subjective approaches, reflecting the very nature of the subject matter itself.

The concern of this chapter is the program's potential for the prevention of emotional disorder. This rationale takes three forms: (1) fortification of ego, (2) greater comfort at school, and (3) recruitment and the spread of effect.

Fortification of Ego

A person's ability to cope with life can be buttressed in several ways, not the least significant of which is the accumulation of knowledge. Those most successful in handling the problems of living appear to be those who are best equipped with the skills and information required. Our educational philosophy is predicated on the faith that knowledge will find its own rewards. Elementary grade children are still fairly close to the developmental decisions which will mold their personality; they are, for the most part, still free of

6

inhibited thought and behavior. Teaching them in a logical sequence the substance of accumulated knowledge about the behavioral influences of inheritance, environment, social systems, intelligence, learning, emotions, the order of birth, mental illness, the concept of self, the effects of alcohol and other addictive substances, etc.; reviewing with them in a retrospective and anticipatory manner the developmental issues they have faced and will have to face in the future; and allowing them to experience and/or discover the techniques of inquiry into these matters, ought to be beneficial—if not pivotal in a personal sense—in their encounter with the world of human problems.

However subtle the process of adaptation, and however intricate the relationship between affect and cognitive learning, the mechanisms involved would be enhanced by a direct confrontation with basic behavioral knowledge methodically taught in an objective manner. If skill in the process of behavioral inquiry can be fostered at the same time, further strength or confidence might result. In addition, learning a language or the symbols with which to express subjectively felt tensions and discomforts could lead to increasing the "degrees of behavioral freedom" referred to by Bower (1964) in his discussion of primary prevention.

Greater Comfort in School

It seems appropriate to hypothesize that a study of the behavioral sciences could make for greater ease in the general learning tasks of children and could help them better to understand and appreciate the educational process. Learning is a fundamental concept in the behavioral sciences, and much can be taught in relation to it which could prove beneficial to pupils. Knowledge absorbed about the variety of influences on the learning process should find some personal reference. Comparative lessons on the school as a social system, the social structure of the classroom, and the role-relationships of teachers and pupils may well have immediate application for the student.

Also, the behavioral sciences classroom period might serve as a vehicle for free discussion of perceived problems. This is not to says that the program advocates group therapeutic methods in the classroom or encourages the public airing of sensitive personal issues. Rather, in the spirit of free behavioral inquiry, as found in "show and tell" or in current events discussions, pupils might feel free to bring to the fore behavioral issues which can be examined in an *educationally* productive manner.

Recruitment and the Spread of Effect

Not to be overlooked is the potential spread of effect of this type of teaching, both from the point of view of career choice and the greater public knowledge of the behavioral sciences. Recent listings of honor high school graduates in the Boston newspapers indicated that not a single one of them was planning to go on to major in any of the behavioral sciences in college. Although there could be many explanations for this, a rather plausible one is that they knew little of the behavioral sciences since they had not been exposed to them in their schooling. A careful longitudinal study on career development of scientists (Cooley, 1963) suggested that the junior high schools were of great importance as a point in career choice. Since there is no significant formal exposure to the behavioral sciences in grade school, career choices in these fields would seem to be handicapped. Recruitment problems in the field of mental health are already acute, and attracting competent young scholars to the study of behavior in graduate schools has been a problem for a long time.

Teaching children about the behavioral sciences should spread its effect to parents and the community at large almost immediately. This could help restructure the general milieu in more supportive ways for those who have not succeeded in handling their behavioral inconsistencies. Thus, we may obtain greater community support for professionals working with recalcitrant cases of self-defeating behavior as well as greater public interest in scientific behavioral inquiry.

THE INITIAL PROGRAM

During the 1963-1964 academic year, as part of a school consultation program, the author contracted with the Hingham, Massachusetts school system to teach the behavioral sciences to a fourth-grade class on the basis of a forty-minute period once a week over both semesters (Roen, 1965a, 1967a, 1967b). This experience was gratifying in several respects. The children were enthusiastic and receptive, and it was not difficult in most instances to formulate the concepts and content on their level of understanding. There remained sufficient subject matter, not covered in the time period available, so that the class could have been extended over a considerably longer period of time. Despite the newness of the program and its intrusion of seldom-touched topics, there was no criticism from parents or others in the school community. In fact, newspaper publicity brought forth requests from personnel associated with other school systems in Massachusets for information and consultation directed toward instituting similar programs in their settings.

At the end of the course, the children were given a typical classroom achievement-type test covering the content in order to supplement the subjective impressions of the instructor. The same examination was also given to 25 graduate students taking an advanced psychology course and to 51 undergraduates enrolled in an introductory psychology course. The scores for the three groups were as follows: graduate students' mean = 61, standard deviation = 12; undergraduates' mean = 84, standard deviation = 13; fourth graders' mean = 76, standard deviation = 14. In a very gross way these data suggest that the fourth graders were, indeed, able to master the content quite satisfactorily. This finding, reported more fully elsewhere (Roen, 1965b), together with the highly positive subjective impressions about the program, provided some basis for encouragement concerning this initial venture.

The course of study developed for this initial program may be best understood in terms of the following outline, which was used for planning purposes:

1. What is behavioral science?
    - Psychology, Sociology, Anthropology, Psychiatry.
    - What do you already know about behavior?
2. Behavior is a function of a person and an environment.
    - Why will one child have a temper tantrum and another just give in if their parents refuse to let them watch a TV program? How would you go about trying to find out the answer to this question?
3. The person.
    - List all the ways you are different from a rock.
    - List all the ways you are the same as other children.
4. What, besides your general environment, influences the kind of person you will be?
    - Heredity.
    - Development or maturation.
    - Learning.
5. Heredity.
    - Instincts.
    - Formal interview of mothers to find out what kind of behaviors babies are born with.
6. Development.
    - Which characteristics develop first?
    - One cannot do what one is unable to do.
    - At what points in life are people in different stages of development?
7. Erickson's psychosocial stages of development.
    - How do you know the infant is around and what do you suppose he might be thinking? (Extract from them the function of mouth and its relation to the development of a sense of trust.)
    - How do you know the two or three year old is around and what do you suppose he is thinking? (Extract from them the function of muscles and their relation to the development of a sense of autonomy.)
    - Similarly: boy-girl differences and the sense of initiative.
    - Their current stage and the sense of duty and accomplishment.
    - Also: adolescence, marriage, being parents, maturity, and old age.
8. How does the idea of "I," "me," or "self" develop?
    - What body part do you point to when you say me?
    - Self extension: hair, house, bicycle, beliefs, etc.
    - Self-esteem and ideal self.
9. Learning.
    - By what different ways do we learn?
    - Condition them to raise their hand at the sight of a card.

  - Pavlov's dogs and how animals who are conditioned could be used to serve man.
  - Stimulus, reinforcement, extinction, generalization, etc.
  - How could you use conditioning to help people with bad habits?

10. Classroom experiment with pupils as subjects on retroactive inhibition.
    - An example of how psychologists discover facts about learning.
11. Rote learning.
    - Best ways to memorize: intent to learn, meaningfulness, distributed practice, active performance, organization and rhythm.
    - Demonstration of memorizing a grocery list through association.
12. Trial and error learning.
    - Construct a maze and through discussion encourage learning experiments with animals.
    - How do rewards and punishments influence learning?
13. Insight and thinking.
    - Examples of solving certain puzzles by changing set.
    - Daydreaming as a form of thinking.
    - Creative thinking.
    - Reasoning.
14. Doing, knowing, and feeling: their relation to muscles, head, and organs.
    - Feelings and bodily changes—lie detector test.
    - The emergency functions of emotions.
15. The psychosomatic concept.
    - What may happen to the body when strong emotions last for long periods of time?
16. Emotions.
    - Attaching names to feelings: anger, fear, anxiety, pleasure, love, etc.
17. Anxiety and psychological pain.
    - Their examples of how anxiety is different from fear.
    - Anxiety as an opportunity for growth.
    - Neurotic anxiety and the temptation to escape.
    - The handling of anxiety.
18. Doing, and the motives of man.
    - Physiological motives and the planning of an experiment with animals to discover the relative strength of drives.
    - Personal motives.
    - Unconscious motivation and hypnosis.
19. Knowing and intelligence.
    - Their definitions of what intelligence is.
    - The IQ.
    - Social and cultural influences on the IQ.
20. Environment.
    - Library assignment on the experiences of children in other cultures.
    - Race and religion.
21. Demography and social structure.
    - Urban, rural, and social class.
22. Institutions.
    - What "institutions" influence their daily lives: political, legal, educational, religious, family, art, science, and medicine.

23. Sociological analysis of the classroom.
    Comparison of their classroom structure and roles played with a neighboring class.
24. Personality and environment.
    The effect of birth order on rivalry between children and relationship to parents.
25. Biographical integration.
    Write an autobiography that emphasizes your uniqueness as a person and explains the influences that have made you different from others.

The course of study outlined above borrowed heavily from general psychology since this was the author's unavoidable bias. However, collaboration of an interdisciplinary committee could alter this tentative curriculum so as to reflect the behavioral sciences as an integrated whole. Some of the units outlined above extended beyond one period, and many of them could have been elaborated to cover longer periods of time. There would be little difficulty in enriching the current outline, especially toward the end, to cover a two-year period. It is felt that with some effort a curriculum of fruitful teaching could be designed to cover the six years of elementary schooling.

The teaching method attempted to motivate the children to conduct their own inquiries into behavioral phenomena. Whenever applicable, research studies were devised and carried through by the children. The classroom itself proved to be a fairly adequate laboratory for many of the lessons. The regular classroom teacher sat in on the lessons and tried to integrate the subject into the rest of her curriculum, i.e., included the new words in her word stacks. Interspersed through the outline presented were review lessons and classroom tests. The children kept a special notebook on the behavioral sciences which they referred to for review purposes. A more detailed account of some of the class sessions has been presented elsewhere (Roen, 1967a, 1967c).

EXTENSION OF THE PROGRAM INTO A RESIDENTIAL SETTING

A. J. Burnes (1966), a research fellow at the South Shore Mental Health Center, as part of his consultation activity at the Hampshire Country School, a residential treatment school in New Hampshire, has extended the behavioral sciences teaching program to include a behavioral science laboratory. In the context of discovery, he has taught his pupils to build apparatus for the solution of specified questions on behavior. Among the homemade equipment to be found in his laboratory are teaching machines; operant conditioning devices for rats, monkeys, pigeons, and perch; an analogue computer; an anesthesiometer for skin sensitivity; and apparatus for mirror tracing, depth perception, and color constancy.

Of prime importance in his laboratory is the simplicity of the instruments. Arguing that sophisticated experimental devices have little meaning for those who cannot appreciate or understand the inner working of the apparatus, Burnes has built his laboratory of simple articles which typically have other purposes in everyday life. For example, a long cardboard cylinder mounted on wood serves as a spontaneous method for studying level of aspiration when he, without prediscussion, puts the cylinder on the floor, stands upright, and tries to drop pennies into it. The children soon become engrossed in this task and play the game too. A few questions, strategically asked, serve to motivate experimental inquiry into the dynamics of wanting to improve scores.

In similar fashion, an inquiry into whether the skin reacts to emotion is undertaken through the use of a 1.5 volt battery, paper clips, rubber bands, a homemade armature, nails, a nylon watchstrap, bell wire, a ballpoint pen refill, polished quarters, and a music box drive and roller. The measurement of skin resistance as a variable in strong emotion is in this way grasped by the student. In evaluating this experience Burnes states, "It is more important for children to learn how to inquire than for them to know facts; we are not so much interested in developing retrieval skills for getting back information about behavioral science which is presumed to be true, but are far more concerned with how a student can self-initiate investigations of a particular issue" (Burnes, 1966, p. 22).

EVALUATING THE EFFECTIVENESS OF THE BEHAVIORAL SCIENCES TEACHING PROGRAM

During the academic year following the initial demonstration, Bartolo Spano (1965) did a doctoral dissertation for the University of Florida on the behavioral sciences teaching program. The Quincy, Massachusetts, school system had been interested in instituting a similar program and made classes available to him on an experimental basis.

Spano designed his study primarily to find out what effect a behavioral science teaching program had on pupils. He hypothesized changes in such variables as causal thinking ability, personality traits, democratic behavior, critical thinking, mental health assets and liabilities, and self-peer perception as a function of exposure to a behavioral sciences teaching program. A secondary purpose of his research was to test for possible differential impact of such a program on children from differing socioeconomic backgrounds.

For research purposes, he selected an experimental class in each of two schools from divergent socioeconomic neighborhoods; for controls he matched each class with another class in the same school on the basis of IQ, grade achievement, and chronological age. The four classes were all on a fourth-grade level. A socioeconomic index showed the children from the school in the lower socioeconomic neighborhood to be significantly different from the school children in the middle-class neighborhood. Both experimental and control pupils were tested one week prior to the initiation of the behavioral sciences course and at the end of the final class. The teaching program was conducted on the basis of one fifty-minute period per week over a five-month period. Twenty lessons were taught by the experimenter, with the classroom teacher attending and taking notes. The planned class content included: (1) introduction to the concept of individual differences, (2) the complexity of causes underlying human behavior and the varying methods of obtaining information regarding causes, (3) introduction to the sources of individual differences —heredity, maturation, and learning, and (4) detailed discussions of various stages of development.

For before and after measurements, Spano used various instruments. He fashioned a revision of the original Causal Test by Ojemann (Huang, 1943), consisting of eight descriptions of behavior, each followed by a series of true-false items offering choices in the interpretation of the previously described behavior. Spano conducted a one-month test-retest reliability study of the revised version of the test on 56 fourth-grade children and obtained a reliability coefficient of .78. He used the Behavior Preference Record (Wood, 1953) for measuring democratic behavior and critical thinking. The test consists of a series of problem situations followed by three to five possible courses of action, from which the student selects one. For measures of mental health assets and liabilities he used the Mental Health Analysis (Thorpe, Clark, & Tiegs, 1959). To measure the personal and social adjustment of the pupils he used the California Test of Personality (Thorpe, Clark, & Tiegs, 1953). His other measures were obtained from teacher ratings and school records.

After exposure to the behavioral sciences classes, significant changes in the positive direction for causal thinking and democratic behavior were found in the experimental group. Factors which were predictive of these changes appeared to be the initial level of causal thinking, and IQ. (The changes were not, however, differential across socioeconomic levels.) Although critical thinking did not show overall significant improvement in the experimental groups, the experimental class defined as lower socioeconomic showed significantly greater growth on this variable when compared to the higher socioeconomic experimental class. This finding may have been due to initially lower scores of the low socioeconomic group on this variable or to the fact that these children are usually underexposed to critical thinking and therefore catch up quickly when given the opportunity.

The lack of significant positive changes in the other variables measured does not necessarily mean that a behavioral sciences teaching program has no effect on them. Spano quite appropriately cautions that there were some serious limitations to his study, including the difficulty of accurately measuring these variables, the low sensitivity of the instruments for assessing change, and the very short exposure of the children to the program. Further research should include a teaching exposure of a year or two, if not longer. More "in-depth" assessment procedures would also be in order.

One secondary finding of the Spano study is of particular interest. After partialling out the effects of IQ, a significant initial relationship was found between causal thinking and social adjustment. In addition, although middle-class children were significantly more causally oriented than lower-class youngsters to begin with, when IQ and social adjustment were partialled out, socioeconomic status was found not to be related to the initial level of causal thinking. This latter datum lends support to the notion that better causal thinking is genuinely, rather than artifactually, related to better social adjusment. This is particularly true in light of the additional finding that the causal thinker is seen through the eyes of his teacher as one with a creative interest in many facets of his life, including his present school experience.

SEMINAR FOR TEACHERS

If interest in the teaching of the behavioral sciences in the elementary grades is to spread, it should obtain university auspices. Behavioral scientists can demonstrate the reasonableness of the program, but the teaching profession must mold it into the educational process. Toward this end, Lesley College, Cambridge, Massachusetts, has offered graduate school credit for teachers in a seminar, "Teaching the Behavioral Sciences to Children."

A more elaborate report of the seminar, which was offered in the Fall semester of 1965, has been detailed elsewhere (Roen, 1966, 1967b). Besides regular grade school teachers, the course enrolled teachers of special classes and kindergarten teachers. Assignments included creating lessons based on Berelson and Steiner (1964), *Human Behavior: An Inventory of Scientific Findings,* which was used as a text. The participants taught their lessons to their classes, paying attention to special methods and materials, and reported back to the seminar.

A first-grade teacher fashioned a lesson on the transfer of training by having children memorize three sets of words and analyzing with them afterward why it was easier to remember some of the words than others. A second-grade teacher focused on "why children tattled" and worked up a dictionary lesson in which the words tattling, telling, gossip, idle, etc. were semantically differentiated. A third-grade teacher devised a lesson on "habit formation" in which she conditioned the class guinea pig to climb a box for food when a bell was rung. A fifth-grade teacher focused on "the blackout of November, 1965," and formulated a series of lessons that studied the differential reactions of children and adults. She focused on questions such as whether fear is acquired, how morale can be maintained in crisis situations, and how events are reported in the media of mass communication. A remedial reading teacher took the bull by the horns and taught her group "visual perception and organization as applied to reading." A teacher of a special class of slow learners taught a lesson on "being afraid" by eliciting from the class the fact that most of them were fearful of lightning and then demonstrating to them, using a balloon and a static electric charge caused by rubbing the balloon, that a spark will fly in a darkened closet. The children discussed the generalization that one is less afraid of what one understands. A kindergarten teacher focused on "fear" by reading to the class the story of "Little Red Riding Hood," analyzing it with them in relation to how the pupils overcame some of their own fears when they were little.

The seminar drew sufficient interest and attention that the Hingham, Massachusetts, school system asked to have one exclusively for its teachers the following semester, and Lesley College has instituted the seminar as a regular graduate school offering.

FURTHER IMPLEMENTATION

This chapter has described a classroom approach to the primary prevention of emotional disorder through the substantially cognitive strategy of teaching the contents, methods, and way of thinking of the behavioral sciences. Representation of the behavioral sciences in the elementary school curriculum may serve to focus the needs for education and remediation in the field of mental health. When and if schools begin to implement a program related to what is outlined in this chapter, local variations may well be able to encompass exercises even more relevant to mental health. Such a development seems especially possible in light of the extension of consultation programs emanating from community mental health centers to the schools.

There are several ways in which further implementation of the behavioral sciences teaching program can proceed. Mental health professionals working in the community and with schools can continue to stimulate interest by entering the classroom themselves to teach. Aside from the direct effect on the children taught, this type of program influences other teachers in the system, the community at large, and the thinking of school administrators. Better opportunities for consultation frequently emerge because the professional himself is experiencing the teaching process first hand, and his role within the social system of the school makes him less threatening.

Another path toward implementation might be supplementing the general training of teachers. Special seminars, similar to the one described, can stimulate teachers to make room for the behavioral sciences in their classroom program. In the initial project, the classroom teacher borrowed time from either the science program or the social studies area, and sometimes a little from both. If teachers in training can be helped to formulate lessons and to think causally themselves, and if they have access to authoritative curriculum material, they may well feel comfortable enough to embark on this type of program.

A third method of implementation, not at all in conflict with the other two, is most compelling of all. This approach would be to interest behavioral scientists to organize an elementary school curriculum, based on a study of the "simple structure" of their sciences, much in the manner of what has been done for mathematics and physical science. Special committees could evolve curriculum materials, appropriate methods of teaching, texts, and simple apparatus. Creators of teacher education programs might then be motivated to develop special programs for "behavioral science teachers." These teachers could serve in the increasingly popular team-teaching programs or as teacher specialists like those in music, art, and, more recently, science.

The "behavioral science teacher" might also be provided with some guided exposure to clinical issues so that subject matter could be taught with sensitivity and special awareness. Recruitment of potential teachers to this new specialty ought not to be a problem. Many students major in psychology and the other behavioral sciences in their undergraduate years; because they have no desire to go on to graduate study, they become public school teachers in areas which are not their first love.

REFERENCES

Berelson, B., & Steiner, G. A. *Human behavior: An inventory of scientific findings.* New York: Harcourt, Brace & World, 1964.

Biber, B. Integration of mental health principles in the school setting. In G. Caplan (Ed.), *Prevention of mental disorders in children.* New York: Basic Books, 1961. Pp. 323-352.

Biber, B., Gilkerson, E., & Winsor, C. *Basic approaches to mental health: Teacher education at Bank Street College.* New York: Bank Street College, Publication No. 62, 1959.

Bower, E. M. Primary prevention of mental and emotional disorders: A frame of reference. In N. M. Lambert (Ed.), *The protection and promotion of mental health in schools.* Bethesda, Md.: U.S. Dept. of H.E.W., 1964. Pp. 1-9.

Bruner, J. S. *The process of education.* Cambridge, Mass.: Harvard, 1961.

Bruner, J. S. The growth of mind. *Amer. Psychol.,* 1965, *20,* 1007-1017.

Bullis, H. E. How the human relations class works. *Understanding the Child,* 1941, *10,* 5-10.

Burnes, A. J. Laboratory instruction in the behavioral sciences in the grammar school. In B. Gertz (Ed.), *Behavioral sciences in the elementary grades.* Cambridge, Mass.: Lesley College, Second Annual Graduate Symposium, 1966. Pp. 14-25.

Cartwright, R., & Biber, B. The teacher's role in a comprehensive program for mental health. Paper presented to the Fifth Institute on Preventive Psychiatry, Univer. of Iowa, Iowa City, May 14, 1965.

Cooley, W. W. *Career development of scientists: An overlapping longitudinal study.* Cambridge, Mass.: Harvard Graduate School of Education, 1963.

Gross, R. Two-year-olds are very smart. *The New York Times Magazine,* September 6, 1964, p. 10.

Group for the Advancement of Psychiatry, Committee on Preventive Psychiatry.

Promotion of mental health in the primary and secondary schools. Topeka, Kan.: Author, 1951. Report No. 18.

Huang, I. Children's conception of physical causality: A critical summary. *J. Genet. Psychol.*, 1943, *63*, 71-121.

Joint Commission on Mental Illness and Health. *Action for mental health.* New York: Basic Books, 1961.

Levitt, E. E. Effects of a "causal" teacher training program on authoritarianism and responsibility in grade school children. *Psychol. Rep.*, 1955, *1*, 449-459.

Lippitt, R., Lippitt, P., & Fox, R. *Behavioral science education for the young: A laboratory approach to social science education.* Ann Arbor, Mich.: Author, mimeographed, 1964.

Loftus, J. J. New York City's large-scale experimentation with an activity program. *Progressive Education*, 1940, *17*, 116-124.

Loftus, J. J. The activity program in N.Y.C. schools. *J. Educ. Sociology*, 1943, *17*, 65-124.

Muuss, R. E. The effects of a one- and two-year causal learning program. *J. Pers.*, 1960, *28*, 479-491.

Ojemann, R. H. *Developing a program for education in human behavior.* Iowa City: State University of Iowa, 1959.

Ojemann, R. H. Investigations on the effects of teaching an understanding and appreciation of behavior dynamics. In G. Caplan (Ed.), *Prevention of mental disorders in children.* New York: Basic Books, 1961. Pp. 378-396.

Ojemann, R. H., Levitt, E. E., Lyle, W. H., & Whiteside, M. F. Effects of a "causal" teacher training program and certain curriculum changes on grade school children. *J. exp. Educ.*, 1955, *24*, 95-114.

Ojemann, R. H., & Snider, B. Effects of a teacher training program in behavioral science on changes in causal behavior scores. *J. Educ. Research*, 1964, *57*, 255-260.

Roen, S. R. The behavioral sciences in the primary grades. *Amer. Psychol.*, 1965, *20*, 430-432. (a)

Roen, S. R. The behavioral sciences in the primary grades: Can children learn the subject matter? *Teaching of Psychology Newsletter*, August, 1965, p. 4. (b)

Roen, S. R. The study of behavior by children. In B. Gertz (Ed.), *Behavioral sciences in the elementary grades.* Cambridge, Mass.: Lesley College, Second Annual Graduate Symposium, 1966. Pp. 3-13.

Roen, S. R. Teaching the behavioral sciences to children. *Bull. Instit. Child Study*, 1967, *29*, 21-31. (a)

Roen, S. R. Behavioral studies as a curriculum subject. *Teachers College Record*, 1967, *69*, 541-550. (b)

Roen, S. R. Teaching the behavioral sciences in the elementary grades. *J. School Psychol.*, 1967, *5*, 205-216. (c)

Rosenthal, S. A fifth grade classroom experiment in fostering mental health. *J. Child. Psychiat.*, 1952, *2*, 302-329.

Seeley, J. R. The Forest Hill Village project. *Understanding the Child*, 1954, *23*, 104-110.

Spano, B. J. Causal thinking, adjustment and social perception as a function of behavioral science concepts in elementary school children. Doctoral dissertation, Univer. of Florida, December, 1965.

Stiles, F. S. Developing an understanding of human behavior at the elementary school level. *J. Educ. Research,* 1950, 43, 516-521.

Taba, H. *Reading ladders for human relations.* Washington, D.C.: American Council on Education, 1949.

Thorpe, L. P., Clark, W. W., & Tiegs, E. W. *California test of personality—manual.* Monterey, Calif.: California Test Bureau, 1953 revision.

Thorpe, L. P., Clark, W. W., & Tiegs, E. W. *Mental health analysis—manual.* Los Angeles, Calif.: California Test Bureau, 1959 revision.

Wood, H. *Behavior preference record—manual.* Los Angeles, Calif.: California Test Bureau, 1953.

15

ENHANCING THE CLASSROOM TEACHER'S MENTAL HEALTH FUNCTION

William C. Morse
University of Michigan

OVERVIEW

The fact that there has been no clear and broadly accepted concept of school mental health programming attests to the complexity of the task. For example, Allinsmith and Goethals in *The Role of Schools in Mental Health* (1962) are more explicit in identifying and describing problems and basic conflicts in this area than in establishing their resolutions.

Over the years the Michigan Society for Mental Health has encouraged a series of efforts conducted by various specialists with the intent of stimulating school mental health programs. The pilot programs have included attempts at universal sensitization of total staff (even cafeteria cooks and custodians) to problems and needs in this field, using techniques ranging from mental health films and discussions to psychiatric consultation and didactic lectures. Other groups have indoctrinated school personnel with rational therapy as the final salvation. Several state conferences were convened to explore common ground and reasonable program designs; these produced no unified theory or direction for the mental health role of the public school system. In fact, even the perimeters of responsibility were never made clear.

By now it has become obvious that the vastly increased complexity of the teacher's task constitutes the basic dilemma in school mental health. Schools have proliferated the "helping" specialists of various sorts, but the collective efforts of specialists have not been sufficient to mitigate the strain that the teacher feels as a result of her many responsibilities and a polyglot classroom population. Indeed, in some instances, specialists, by emphasizing teacher "shoulds" while failing to provide reasonable "hows," have made teacher anxiety higher. For example, mental health as a goal and a responsibility is often presumed by the helping profession to include some appreciation of unconscious motivation. To some there is the further implication that all behavior has to be handled in a manner which reflects underlying psychodynamics.

When this stance is suggested for teachers, it tends to immobilize them in the face of day-by-day classroom difficulties. When just such a classroom situation was examined (Morse, 1961), through interviews and questionnaires, it became clear that master teachers were trying to help as best they knew how with concrete day-to-day problems; and most were doing a creative job under pressure. There was an openness and willingness on their part to accept any reasonable assistance. At the same time, the typical mental health professional in the schools was more interested in his own discipline and in one-to-one relationships with pupils than in helping the teacher with classroom problems. There was actually great uncertainty about limits of responsibility. Some teachers asked whether they were hired to conduct detention homes, mental hospital programs, or public school classrooms.

Factors influencing learning, particularly under the then current post-Sputnik goal of academic achievement for everybody through the new curricula, were generally left out by mental hygiene experts. A naïve rationale that a happy child will be more enthusiastic about learning due to his contentment is still common in mental health efforts. Mental health programs were being sold as the key to automatic motivation rather than as having the goal of improved pupil adjustment—a valuable end in its own right. Major specialist time was invested in diagnosis, with which specialists were most familiar and comfortable, not in establishing prognoses or in specific planning which, though perhaps more cogent, they knew less well. Consultation was flavored with experts talking down to the teacher or producing inscrutable reports. Of course there were, and are, notable exceptions, but the helping professions often bring their role-baggage into the schools and neglect to recognize the systems within the total educational milieu.

THE EVOLUTION OF CORE CONCEPTS IN A SCHOOL MENTAL HEALTH PROGRAM

The following material opens with a brief account of the development of the Michigan program to be reviewed in the present chapter and a description of some of the early efforts of that program. Next, an overview of the problem-centered approach is presented. A description of the present program and related research efforts concludes the chapter.

It is significant that the three persons with major responsibility for the development of this approach were, at once, involved in both the most traditional and most experimental methods of fostering mental hygiene practice. On the one hand, all participated in teaching college courses in child dynamics and mental hygiene to teachers. At the same time, the team members were also participating in a graduate laboratory training setting which involved direct confrontation with emotionally disturbed children in a summer group therapy camp. The staff was responsible for therapeutic planning for seriously disturbed boys. Direct confrontation taxes theory and practice alike, as well as both the "student" and the "teacher."

It is hard to imagine two more different approaches than the typical college classroom and an action laboratory. A gradual disenchantment with the potential of the college classroom developed in spite of the fact that various simulation exercises were used to create an artificial reality. Every effort was made to encourage teachers to work directly with their pupils and to write reports and materials on their own classroom situations. Yet it was obvious that this was much less than a second-best approach to helping teachers change their behavior through systematic growth.

The particular program to be described is not offered as unique. It is the product of gradual evolution, and the present formulation is a consequence of cross-fertilization from educational, school, and clinical psychology. It reflects a gradual movement from the traditional to an open, experimental methodology. Research and evaluative schemes have served as monitors. While this mental health program borrows from many sources, it is hardly eclectic since it has come to constitute a particular point of view.

Through joint efforts with the Michigan Society for Mental Health[1] several programs were tried to bridge the gap between the reality we had experienced at camp and the happenings in a college classroom. The Society supported experimental work through a special grant.[2] To vitalize the teaching of mental health meant to move from the academic to more practical experience related to the teacher's day-by-day activities. The program developed in an effort to meet these objectives spanned several years and included projects in over a dozen school systems, but their principal elements can be covered quite simply.

Schools were asked about possible in-service mental health work. Each system was studied for potential promise by an on-the-spot worker who interviewed teachers, administrators, and local citizens to achieve a better understanding of the actual dynamics of the system. Frequently administrative interest is a poor index of the actual staff interest. Programs may be needed but not wanted. The concept of a "hospitality index" evolved. For example, if teachers requested released time or special dispensation for meetings, it seemed probable that the actual interest in the program was lower than where teachers indicated an interest in participating on their own time. When motivation was marginal, an unbelievable amount of haggling over arrangements took place. Another hospitality item was the willingness of the system to provide incentives; still another was the willingness of teachers to contribute actual data on both themselves and their pupils. Locations with wide differences in motivation were selected to begin work. The basic premise was that the mental health worker would enter the situation and start wherever the particular group was ready to begin. Sometimes the participating group comprised the total school faculty. Other times, only subgroups were interested. In the end the program proved to be a relatively comprehensive one which, over a three-year period, involved some 20 school districts with approximately 1000 participating teachers (Kipfer, 1959).

---

[1] Mr. James Kipfer was director of the School Mental Health Project for the Society for Mental Health. Annual reports are available.

[2] This work was made possible by a grant from the McGregor Fund of Michigan to the Michigan Society for Mental Health, August, 1959.

If one takes seriously the stipulation of starting where the faculty wishes to start, what takes place will, to a large extent, be idiosyncratic. Actual activities ranged from general meetings on the nature of mental health to very specific projects such as how to set up a counseling program. In a few instances, a modified group therapy program evolved. For example, after case conference meetings in the afternoon, certain individuals wished to remain for an evening of group discussion. While such meetings began with discussions about pupils, they often moved to discussions of roadblocks in the school system and personal problems. Individual consultation was provided and referral sources located for help with nonschool difficulties.

The consultants assumed a variety of roles. There were ordinary content meetings using lectures and films on such topics as mental health, hygienic discipline, evaluation, and personality theory. Case conferences on problem pupils were popular. Much time was devoted to consultations with individual teachers about their classes. Meetings were arranged to discuss matters with certain parents. Children were seen for diagnostic interviews and planning. Small group study projects on marking, teacher feelings about pupils, and new approaches to curriculum were organized. There was a great deal of consultation with administrative personnel regarding school problems of various sorts. When proposals required board action, it sometimes became necessary to meet with school board members. Forum-type meetings provided a liaison for various contending factions, both overt and covert, in the school milieu. The common denominator was to offer psychological help wherever the consumer saw a need. It may be judged that this smacks of omnipotence, but this was not the case. The fundamental element was the knowledge that psychology as a tool could bring further understanding in a variety of areas. Admittedly, there were times when the amount of new insight was minimal, notwithstanding a problem-analysis and "solving" format. While the application was most difficult, the belief that psychology has an essential contribution to make in all facets of school practice was, and continues to be, the underlying assumption. The consultants had to work *with* people rather than *on* them; they had to respect their integrity rather than try to change them. Changes are a by-product of working together on problems.

The eventual impact of a meaningful school mental health program lies in the hands of the classroom teacher. Any major change in the school establishment involves *in situ* capability. The elements of the mental health program are facilitators to the classroom portion of the school activity. This viewpoint implies intrinsically that the adjustment and learning facets of the child's life cannot and should not be separated. Consultation on mental health takes place in a vacuum unless academic learning conditions are treated as matters of equal importance. In addition, classrooms are group operations. If this is not kept in mind while planning, teachers will find the new ideas of little value. Thus there must be a heavy emphasis on matters relating to groups, group discipline and control, and the group setting for academic learning.

Any assumption that teachers are ineffective was rooted out at the start by open discussion. Teachers do the very best they can, given their current circumstances. Only when they test and find more serviceable concepts to replace old ones, and only when unfavorable working conditions can be alleviated, have we a right to expect change.

For two years the several consultants worked quite independently, each with his own style and each responding to the unique aspects of his local school situation. Could the experiences be pooled and a fresh start made subject to systematic assessment? The next section reports the research done on one specific school mental health project that was the outcome of this exploration.

The Clinical Management of Education

The overall philosophy of the program that evolved was reflected in its title, The Clinical Management of Education (McNeil, Cutler, & Morse, 1963). The problem was to discover more effective means of adding the depth of psychological knowledge to the teachers' repertoires so that they might handle groups and individual children with more insight. What was needed was not a "soft" approach or a "hard" approach (a popular dichotomy among school personnel), but a realistic approach based upon differential diagnosis and understanding of child pathology viewed in the context of normal child development. Group dynamics were prominent. Since the teacher is always a relationship agent, there was to be no hesitation in recognizing the importance of the teacher's role as well as the significance of the personality configuration of the individual teacher. The nature of the classroom interactive process, which is in part produced by teacher personality, was no more taboo than were the interactive processes involving consultant personality and teacher. The sacred cows in most school mental health work continue to be these very factors, which must be dealt with rather than ignored. Does the typical specialist view normal imperfections in teachers (as in all of us) as "sickness," with all that implies? Does this mean that discussion of school matters constitutes "treatment"? It may as well mean that consultants mistrust their capacities in this area when the "client" has freedom to reject the help. In actuality, the teachers were the leaders in psychological honesty and were displeased with pussyfooting, which, in essence, was a show of mistrust.

The next issue was the content of the service aspect of this project which was to be subject to research. The activities were those the school personnel indicated as desired. Seminars meeting every other week were organized by the administrative personnel. The method was free discussion, with the psychologist serving as commentator and problem clarifier. The effort was to encourage frank talk focused on a psychological examination of the issue. Considerable time was spent on analysis and handling of day-by-day issues with teachers and specific pupils. Time studies were kept of teacher activities. In a large school system the interlocking roles of the administrative hierarchy was a matter of almost constant attention. The principals felt pressures from the superintendent's office and from the classroom teachers they were supposed to lead. Styles of leadership, "discipline" versus mental health, feelings about imposing one's ideas on others, and the nature of the job which had to be done were at issue. Whatever the point of departure, most philosophical and practical matters regarding education came up for discussion during these meetings. Seminars were held with the school specialists, the psychologists, counselors, nurses, speech correctionists, and school social workers. Assistance programs were arranged for the classroom teachers in bi-weekly meetings.

But the chief emphasis was on direct work with volunteer groups of elementary and junior high school classroom teachers. Of the 30 teachers starting in the program, about two-thirds remained active for the year. Meetings and individual consultation about problems took place on request of the teachers. General content presentations were used only to get under way. There was no implication that this procedure or later consultation would actually solve the problems of child management. Subgroups formed interested in attacking particular problems, and a great deal of time was spent on methods for working with individual children. Some teachers were seen individually every week, while others resolved their immediate problem quickly. The junior high group was most concerned with aggressive and underachieving pupils. Several specific subgroups formed to deal with particular problems, and a special program was developed to assist pupils low in skills and talent. An attempt to work on problems of delinquency and aggressive behavior with the high school faculty failed to generate sustaining interest. An active small group of elementary teachers took up the problem of transition to junior high and worked out a gradual transition program which they felt was suitable for the early junior high age.

Special meetings were developed for parents. Since parent cooperation was necessary for research, considerable attention was given to the nature of research plans and possible contributions from parents. As the situation evolved, certain parent groups became the most interesting aspect of the whole program, and an intensive parent study group with leadership training was organized.[3] This group wished to provide leadership for more fundamental

---

[3] Dr. Alan Menlo, School of Education, University of Michigan, was responsible for this part of the work.

PTA meetings and engaged in sensitivity training, study of resource material on child care, and methods of getting a higher degree of parent involvement. Again, profound issues about child raising, the changing culture, parent responsibility, and how to bring home and school closer together were brought up for discussion.

The complete effort at evaluation has been described by Cutler and McNeil (no date). In brief, the teachers supplied biographical information and professional histories. They also indicated the nature and type of help they expected and, at the close, their degree of satisfaction. The knowledge of mental health concepts before and after the program was also assessed. An adjective checklist was used to assess a self-perception of participants and the type of resource person they viewed as ideal. A sentence completion test was used to assess attitudes about teaching children, teacher-pupil relationships, and various self-concepts, both ideal and real. There was also a knowledge test of mental health concepts. These measures were used with 163 teachers and were given twice: once at the beginning of the program and again at the end. Parent information was obtained relevant to 56 variables, including attitudes toward teachers and school effectiveness, the PARI parent attitudes scale, and ideal and real self-descriptions. Pupils filled out questionnaires on the way they perceived their classrooms. Questions dealt with the style of classroom teaching, school anxiety, motivation, mental health matters, and group relationships. In all there were 19 such variables extracted from the children's data. Experimental and control groups were tested in the fourth, sixth, and ninth grades.

The results show that teachers who participated in the program moved toward seeing themselves more positively. They viewed themselves as having more ego strength, being less complaining and timid, as well as being more generous in their judgment of situations. This is, of course, a change in self-perception. On a sentence completion test, they moved from ignoring, excluding, or punishing troublesome children toward methods seeking positive control over the child. These were able, friendly teachers to start with; while they oriented themselves more to persons than content as time went along, the main result was an increase in self-perceived ability to manage the difficulties they faced —i.e., a growth in their sense of competence. A general strengthening of the teacher's classroom position, directness, assertiveness, and self-confidence occurred. It is also interesting to note that there was no increase in their mental hygiene content information at the close. Actual knowledge level showed no gains although there were many substantive experiences in the program. In regard to the degree of participation, the more intense the participation in the program, the greater the change. The younger, less experienced elementary teachers were most susceptible to change.

This ego strength development in the teachers was paralleled by the change in the experimental group of parents. They became more definitive in their relationships with their children—less a pal and more of an authority.

They became less uncertain and less uneasy, which is not to say punitive or harsh. There was a decrease in both "parent-deification" and attempts at "will-breaking" and more willingness to allow children to live their own lives. Parent and child roles were separated more clearly. More involvement in the school program also took place.

The analysis of pupil changes brings us to what eventually is the central point of departure—the diverse nature of classrooms, each representing an idiosyncratic complex equal to that of an individual personality, but perhaps more complicated. Since, of course, the teachers were not alike to start with, changes could not be identical. Further, the impact of such individual changes on a highly variant series of classes imposed a most difficult task of analysis. Some of the classes taught by teachers in the program became more work-oriented but also more anxious; others became more comfortable and less work-directed. The more ideal goal of reasonable structure, high acceptance, and high motivation is the one stated by Cutler and McNeil as the most likely direction of change found in their analysis of individual classes. Overall, the teachers in the program at the close were seen by pupils as less nagging and punitive, but setting strong limits and giving support that reduced anxiety. Since general classroom morale tends to decline as the school year progresses, the effect of the present mental health program was to arrest or reverse this trend. Further analysis of individual classrooms has led to far more sophisticated appreciation of the difficulty in surmising reasons for pupil changes (Ketcham & Morse, 1965).

Thus, the research, tentative though it is considering the complicated problem and the inadequate instrumentation in this area, does indicate that the mental health program helped the adults, both parents and teachers, to develop a more defined and secure role in their work with children. Perhaps they were helped to overcome uncertainty and indecision. As a result of exposure to this program, they came to their new patterns not reflexively but having faced the deeper problems of our time. They thought through their beliefs and found procedures that were suited to their relationships with the children.

The pupils' classroom adjustment is a many-faceted affair. Changing one aspect may influence another in a direction not intended. Contentment without effort is not enough, and the interrelationship of the various classroom conditions is more complicated than changes in an individual personality. Facile single measures may be more misleading than helpful in this area.

INGREDIENTS OF A VIABLE SCHOOL MENTAL HEALTH PROGRAM

The genesis of the Michigan approach to school mental health programming has been reviewed, and the research findings related to a specific program have been presented. Since the content of any individual program follows the perceived needs of a given school clientele, there is no set routine which has become an accepted format. The point of access and activities depend upon the locale; on the other hand, one may often find shared goals and a common starting point in different schools. Finally, there are action aspects which, though not inevitable, often appear at some time in a program because of the generalized presence of particular problems and potential lines for their resolution in the school milieu.

McNeil, Cutler, and Morse (1963) indicated four primary goals of a school mental health program: (1) to increase the teacher's sensitivity to individual and group psychological problems, (2) to present diagnostic procedures which will direct the teacher's efforts along more sophisticated and complete dimensions, (3) to study the management of the learning process according to the principles of good mental health, (4) to translate the theoretical knowledge of psychology into practical action.

To this end there are certain processes which become a basis for program operation. The first is defining the relationship of the mental health consultant as co-equal, rather than as superior. He has particular knowledge to contribute in a joint enterprise concerning the solution of classroom problems. Second, the teacher can best begin by a rough rank-ordering of the problems as he sees them—whatever they may be—in order to find an optimal starting point. Sometimes the chosen starting point represents an unrealistic problem or requires more time than is available from the consultant. However, teachers soon become more adept in listing realistic concerns about which something can be done. Indeed, the very process of learning to formulate a functional problem is a most important skill. These problems usually involve children who are difficult to manage because of acting out. But almost as common are problems concerning youngsters who are difficult to teach because they seem not to learn by the procedures adequate for most pupils.

The next step is a search for relevant psychological principles to apply both to diagnostic planning and to a proposed program of action. There must be some actual activity for the teacher to try out, not just abstract theorizing. A rehearsal is often attempted in the consultation or seminar. The teacher then goes about trying to follow a mutually worked out sequence of actions. Generally speaking, teachers are far more effective than "experts" in devising the specific useful classroom strategies. Hence, with a clearly formulated understanding of the problem situation, the teacher himself may be in the best position to develop a concrete plan of action.

The subsequent step is an evaluation of the action. That is, the teacher reports back on what transpired at the next session of the seminar or consultation. Usually the consequence is a reevaluation of the problem and a proposal of new action. Often a more complete understanding of the events indicates the need for help from school specialists to work with the parents, or referral to a clinic. Findings might suggest new designs for classroom experiences. Perhaps the analysis suggested on-the-spot study of particular issues through collecting organized responses from the pupils or making observations in the classroom. Teachers might see the need for learning new techniques in interviewing.

It becomes obvious that for the most part one works with the teacher's perceptions of the classroom events. The assumption is that these perceptions constitute a critical world which is just as "true" a world as would be a therapist's perception of his client's life events. If the teacher and consultant can work together to move from "what actually happened" to what the happening signifies, psychologically speaking, we have the nuclear material for school mental health work. The stance is one of problem solving, with facts and feelings both considered. That this is not as simply done as stated will become evident shortly.

Each consultant must work in his own particular way. Though their goals are common, no two work settings are the same. The unique nature of each psychologist and his capacity to establish meaningful relationships and solve problems—not a set of clichés about the consultee-consultant relationship—determine the course of action to be followed. As consultation programs were established, it became clear that school personnel believed that some push or assistance from the outside was necessary if the consultation program were to be successful, despite the fact that there were able people in the system itself. This may mean that specialists totally within the milieu become too constricted to act in sensitive areas with the necessary freedom. This is a matter of great concern which needs much more careful study.

The following enumeration defines the school mental hygiene program content, i.e., what actually goes on in sessions with teachers. At the present time, certain combinations may find a place in didactic courses, in seminars, and in consultation in field settings. Consultants must be ready to balance open-endedness with structure, since too much of either may create uneasiness. By and large, teachers have been promised more than has been delivered so consistently that there is almost always a testing-out period with regard to what is to be done and how it will be handled. Accordingly, skill in explaining possible ingredients for an action effort is basic to consultation. But the assurance that there are program elements which have evolved from joint work with teachers is important. The consultant first explains the general methods of operation of the program and makes tentative suggestions to get a discussion underway. From this comes the following action steps.

RELIEVING STRAIN

Consultation should relieve the strain about the demands of teaching which most classroom teachers feel. This requires a school-relevant psychological point of view rather than the traditional clinical psychological practice divorced from the school context and school problems. Such an orientation emphasizes things to do rather than abstract principles. An approach that has been found to be both psychologically valid and meaningful to teachers is one that combines depth psychology with the life space or contemporaneous emphasis of Kurt Lewin (Morse, 1965). A basic emphasis here is the contrast between the usual life history approach and the contemporary life space or milieu approach. Most teachers have been indoctrinated with the clinical or life history approach, and there is a tendency to try to explain and to understand human behavior primarily in terms of the past. The daily problems of the pupil are depicted, almost exclusively, as the result of his life history, much of which lies buried in his unconscious.

Thus change efforts require the proper conditions to bring these matters to the surface and, through individual therapy, to create new understanding and rectified behavior. While the foregoing orientation may, of course, be important and sometimes essential, we must also recognize the importance of a contemporary emphasis—i.e., on teaching children to cope with the present difficulties on the basis of learning principles. It is thus proposed that there are other viable methods—alternatives to the psychodynamic depth approach to mental health problems—which should also command respect. It is well within the province of teachers to study and to work to the fullest possible extent with the contemporary life space of the child. The exclusive life history approach leaves them helpless except to refer, which is seldom likely to take place.

The life space theory, as we use it, holds that the distillates of one's life history constitute the present self concept. Thus, dynamics are incorporated, but the emphasis is in terms of their impact on the current field. The working forces of the community and total school milieu will also influence the classroom through impact on pupil self concept. Historical material is not eliminated in favor of the circumstantial or the sociological, but it is jelled in the present self concept and self-esteem of the pupil. The external forces of the here and now, being within the jurisdiction of the teacher, are emphasized. As will be indicated, instruments to deal with these issues have been developed to aid the teacher.

The life space theory further implies that children behave differently—radically so—in various situations. This point is, in part, demonstrated by research done at a therapy camp (Gump & Sutton-Smith, 1955). This work underscores how completely different the adult's role and the child's behavior are in various settings. The same adult may be a policeman in one setting and a helper in another. Environmental forces can stimulate cooperativeness or hostility among peers. Games create varying roles for the same child. All of this means that the contemporary self and the contemporary environment interact to produce behavior. In a well-planned children's psychiatric hospital, for example, the disturbed children may look more normal than not, most of the time, as a consequence of astute environmental planning (Redl, 1959a).

This leads to an issue of major importance. Teachers examine the types of behavior induced by classroom forces. What changes can be made to support the child's capacity to learn and adapt? Obviously the nature of adult-child relationships represents one area for possible change; another is that of the demands of the tasks—how they are presented and evaluated. A third matter is the peer or group relationships produced in the classroom. These latter elements certainly operate in the classroom, but they are filtered through the particular self concepts of the individual pupils. This is the unique part and means that the same input will have very different behavioral consequences for different children. This is a dynamic approach to the teacher's number one problem—individual differences—which, hopefully, is more useful than static age, achievement, or intelligence data since it includes motivation, ideology, and needs.

The total implication of the life space system is to study more and plan more for the conditions about which the teacher can do something. But again, the consultant must point out the power and limitations of this emphasis, lest an oversimplified "either-or" polarization be created. While there are many classroom interventions that can produce a richer and more effective school experience for the child, there is also a limit to this approach. Many times the consultant must help the teacher appreciate the limitations of schools in restoring a long-damaged self concept. At such times, the prime concern becomes that of how to work most effectively with supporting referral services. Of central importance is the need to get away from a pseudoclinical approach to the educational province. In the final analysis, answers to major mental health problems are likely to be found to lie in the classroom itself, and in those things which can be done by the teacher with the children in that environment. Unless we can find better methods of working within the classroom, school mental health programs will falter.

SITUATIONAL ANALYSIS

One of the major skills which teachers can develop is the ability to make a comprehensive analysis of particular children or of a total classroom situation. This embodies essentially a phenomenological approach to the here and now, internal and external life space. What are the forces active in the child's mind? What is the attitudinal system in this class? The important thing is to have tools for looking at these situations from a teacher's point of view rather than to misapply measures that are primarily those of other disciplines. To aid in this process we have developed scales and devices which enable a teacher to study certain aspects of individual pupils, as well as the overall classroom.

There are nineteen major dimensions to this classroom analysis which provide data to chart an individual or group profile on standardized norms. Pupil and the class distributions can be plotted on such dimensions as the following: motivation for school work; perception of the teacher as a helping agent; school anxiety; social acceptance; satisfaction-dissatisfaction with the class structure; perception of the climate for learning; need complex (achievement, affiliation, power); and self concept. In addition, the ordinary measures of educational achievement and intellectual ability are included. Training in the use of these devices focuses attention on the severe limitations of scales and the use of direct observation in combination with such material as a way to collect information for analyzing problems. Teachers are quick to point out defensive reporting of children they may know well. The major purpose of these procedures is to sharpen our intellectual wits, since no device can go farther than the teacher's insight.

Thus, the teacher can look at the response pattern of particular children in school-related domains and see the type of distribution on any of these dimensions for the total class, as adjusted for boys or girls, at any grade. Sometimes it is easier to come to grips with an issue through objective information. Sensitivity to individual children and to classes increases. Two junior high school staffs, using just the self concept measures, generated an interest in working on ways to help many of the children who had been known to have problems but were previously ignored by the school.

SELF ANALYSIS

A vital aspect of the mental health potential of a classroom is obviously the character of the interpersonal relationship fostered by the teacher as a person and as a professional. Many teachers, at one time or another, see value in an analysis of their own behavior relative to the teaching role. But this is not best accomplished by making a teacher the client for the consultant's therapy.

Several devices, including a variety of rating scales, are available to enable a teacher to gain in self-awareness, beyond the inherent by-products of planned discussions. Norms are available on these scales and some are self-scoring, so that a teacher need not identify himself unless he so chooses. On one scale dimensions include value investment relative to learning, mental health, individual differences, or group processes. Another scale categorizes the general stance of the teacher's classroom operation relative to discipline, counseling, referral, etc. Deeper motivational patterns can also be assessed. For example, a teacher may be motivated by a need to affiliate or to achieve. Essential ego strength and self-image of the teacher are very important since they underlie so much else, and these dimensions are reflected in still other scales.

The teacher can now examine a classroom profile, including pupil needs and his own needs. Do they match or are they in conflict? Again the limitations of the devices must be emphasized, and the teacher is urged to check against other types of evidence. No one holds that a really disturbed teacher will be helped by such ego level approaches; it is maintained that normal people can monitor and mitigate particular peaks or valleys in their output, if they appreciate what their style happens to be. In the negative sense, this is certainly no intent to create a single, "ideal," homogenized teacher profile. Rather, the goal is to help teachers to develop their own style in a way that best suits their positive attributes and to strive to hold less fortunate elements under control when trying to help particular children for whom they are responsible. None of these devices are handed out cold. They are used as part of a program involving prior discussion, and any teacher may reserve his own personal data for himself.

It is also clear that the teacher does not necessarily stand pat with the classroom profile which represents the pupils at any point in time. The availability of such profiles provides concrete evidence of the possibilities of specifically planned interventions. If motivation for school work is very low, if pupil self-concepts are marginal, if social acceptance is nil, these become the starting point for planning. Plans must be made with the same care one utilizes in working with an individual, but it is stimulating to see how productive teachers are in thinking of appropriate classroom strategies once the problem is delineated. The purpose of the instruments is to move from global principles to specific and concrete elements for more effective classroom work. Too much mental health effort is still general and is characterized by the rather unspecific platitude "be good to the children."

LEARNING SPECIAL SKILLS

Beyond the analysis of situations and general strategic planning, a teacher may wish to learn new skills for working with children. These comprise the school interventions which teachers practice, but often without adequate sophistication. It has already been indicated that alteration of the tasks, evaluative procedures, teacher behavior, and working through group situations will be part of the action. But this is often not enough. Hence there is a continuing orientation to the acquisition of special skills, including the following.

Skill in Life Space Interviewing

A major necessity for effective work with children in any action setting is a technique for meaningful and profitable verbal discourse with youngsters (Redl, 1959b). This is particularly true in handling acting-out or difficult-to-manage children, but it is also true with unmotivated and passive children. Teachers already spend a great amount of time in interpersonal interaction with the obvious intent of changing the pupil's behavior directly or finding which environmental conditions should be altered. Skill in this area can be upgraded only through supervised practice. However, there are steps for the teacher to follow, and seminars are used to work out the exact things one might try with a child under given conditions. Recordings of interviews, with specific discussions of the content and meaning, become the focus. The way the teacher expresses his empathic concern for the child is to understand him. The way one understands the child is to accept him as he is, as far as his verbal statements go, to listen to him, and to think with him about the way his experiences seem to him.

Considerable time is spent helping the teacher learn to listen. First, the teacher listens to the child and learns his point of view. Other steps follow, such as exploring the depth of the issue, inquiring as to the generality of a particular problem in other situations, and going on to discuss what might be done in such a situation. The teacher explores the child's recognition of the need for change and particular coping mechanisms that might be taught to him. There is always an attempt to close an interview with some minor alteration so that behavior can be more acceptable in the future. The approach is certainly not an easy one, but at least the conversation between the child and teacher should be turned to the most productive use possible. Seminars and field consultation have been devoted to teaching life space interviewing for use with individuals or groups.

The Use of Curriculum Content for Mental Hygiene

Most teachers find classroom content to be the most natural medium for interacting with children. Ojemann (1959) has demonstrated that understanding of behavior can be approached through specific types of conceptual material used with pupils. In addition to the stories and materials which he presents, any story which has dynamic implications or value implications can be used as the basis for meaningful classroom discussion. It seems particularly important that adolescents have the opportunity to discuss concerns which may or may not naturally come up in the course of the semester. Themes, projects, and books can deal with mental health matters. Teachers in areas other than social studies or English have found that anxieties about their subject matter area, grades, or teaching methods represent appropriate areas for scrutiny. For example, for one of the teachers in our program, fear of failure in science and mathematics became the point of departure for discussion. He now routinely uses a brief anxiety assessment questionnaire as an introduction to every math class.

In addition to such curriculum changes, teachers frequently feel it is desirable to set up specific programs for "high risk" youth. Some have utilized group counseling, while others have primarily emphasized remedial work. These activities can be led by the teacher if he has had prior relevant training and if adequate consultation is available to him.

WORK ON INSTITUTIONAL ROADBLOCKS

It is obvious that there may be many built-in chronic roadblocks to optimal mental health in the educational setting. Mental health as primary prevention presumes work to remove these constricting elements. There are some fifteen to twenty prevalent roadblocks which have come up in teacher-discussion groups. These include such things as the limitations of a constant teaching method when populations vary, problems engendered by constant-rate expectations for children at different grade levels, rigid subject matter content in some schools, the fractionation of helping roles (e.g., the principal versus guidance worker, etc.), unsatisfactory evaluation procedures which are prevalent in most schools (here concrete suggestions are made for alterations and more reasonable feedback procedures), the need for greater attention to nonvisible reward systems in schools (Coleman, 1961), the potentially unfortunate consequence inherent in maintenance of classrooms of relatively comparable size even though some pupils need much more teacher help than others, the tendency toward inflexible use of special personal capacities of teachers, and the use of curricula far removed from the lives of children.

Quite probably, such roadblocks as these have more unfortunate mental health consequences in the school than any particular program can hope to eliminate. When teachers are provided an opportunity to consider the potential consequences of change, they become more aware of the need for a total attack on the inanities of certain present educational practices. Flexibility itself reduces many of the problems which now cause serious difficulty. With the increasing emphasis on education, teachers are at a critical stress point. It is also true, as Berlin (1964) has indicated, that serious changes in the psychological motivation of pupils today may be taking place. Teaching cannot remain static in a fast changing social climate. Changes in the school system or in any other entrenched social institution are never easy to effect but accomplishment in any of these areas is fundamental rather remedial, and growth in these directions may be most appealing to the master career teacher.

CONCEPTUAL MATERIAL

There is an obvious place for a fuller understanding of material on childhood dynamics, once a teacher comes to grasp its value. Phenomenological and self concept theory has already been described as "practical" theory which may lie at the core of this approach to the child. There is the further crucial matter of understanding differential diagnosis so that proper handling which, in the last analysis, depends upon the nature of the self being handled, can be accomplished. Basic information on the particular dilemma of a child offers the opportunity for bringing in related conceptual information. The problem has not been lack of need for conceptual information; rather it has been the fact that the particular type of conceptual information offered often pays very low, if any, dividends. When concepts help a teacher work more effectively, there is no resistance.

For example, the screening devices that are necessary to objectify one's impression of a child's adjustment are very useful to teachers, and teachers show a good deal of interest in them. Such simple things as a "bug me" index, which one teacher kept of the daily irritations, or the study of countertransference phenomena help the teacher to operate more effectively. We find no reluctance at all on the part of teachers to study such matters as interpersonal communication, differential diagnosis, the nature of empathic response, various types of pathology, and the like.

The mental health consultants should be aware that a major problem of many teachers involves children with learning difficulties, perceptual and otherwise, so that these aspects are included in the overall consultative program.

USING REFERRAL PROCESSES

It is important to emphasize that many children require referral. Even the most skilled teacher cannot hope to cope satisfactorily with all problems of all children. While the percentage of those who cannot be handled effectively in the classroom may not be large, the guilt, irritation, and difficulty generated by them make the few exceptions an imposing problem for the teacher. The difficulty of getting referrals and the nature of the waiting lists, even when there are good resources, is well known. When no help is available, individualized course plans, a shorter day, or—in extreme cases—even school exclusion may be needed in order to underscore the magnitude of the problem and, perhaps, to put pressure on parents unwilling to acknowledge the severity of the child's problem. This is done not through a precipitous decision, but only after attempts at less drastic procedures by the school have failed. Parents are consulted, and all other possibilities are eliminated.

If nothing is found to alleviate the situation, it becomes obvious that the school is incapable of helping that particular child. If his particular problem is one which does not cause school disturbance, it may be difficult to get additional help, especially so if the parents are unwilling to cooperate. However, if the child is impeding the learning of other children, the school has a responsibility to exclude him, at least for that part of the time when he functions disruptively. Such extreme action is necessary in order to protect the mental health of others in the school and, in the long run, of the particular child as well. Public school masochism, foisted on the teacher as it so often is, has no place in school mental health.

The teachers in some schools have worked with a different referral source —namely a crisis teacher who can pick up the overflow of school problems outside the scope of the group classroom situation. The concept of crisis teacher and its way of functioning are described more fully elsewhere (Morse, 1962). In addition, teachers have become active in working for special classes, mental health clinics, day-care programs, and inpatient care for the community. In a recent study of Michigan's mental health problems it became clear that a major problem was lack of adequate services to handle the few extremely disturbed children. This meant that each service was backed up with cases beyond the scope of its helping potential. All parties concerned, including the classroom teachers, were attempting to solve the problems of children far too disturbed to be handled with the resources available in the given situation, particularly in the average classroom. It is important to be realistic about these difficulties rather than to imply indirectly that teachers should be able to handle all difficulties of all children who walk (or are forced) through the doors of public schools.

CONCLUSION

This has been a hurried journey through a very complex and extensive series of activities. Members of the training staff of consultants in the Michigan program have moved from didactic lectures to direct work through the school milieu. It becomes increasingly clear that the school program is merely a link in a long series of services and that a defect at any point in this sequence burdens others and makes their work less effective.

When it comes to positive action, the anticipation is that each classroom and each school community is unique and requires a particular selection of program elements tuned to the needs of that institution, with its resources, its insights, and its readiness. An external resource person can bring illustrations and the like, but his major contribution is to help analyze the problem and to think, with the people involved, about resources which are available in their situation. Thus, the core of this mental hygiene approach in school is not a given set of things to do, but rather a point of view. In practice, this may lead to setting up a group therapy program, a big brother movement, a program utilizing mental health materials directly in the curriculum, or even a course. The prime function of the outside consultant is to facilitate a problem-solving process by bringing to the attention of the classroom teacher, or others, aspects of the problem and possible ways of seeking a solution. A basic respect for the local school personnel presumes that the consultant comes in to work through and with them on the problems as *they* see them, or come to see them.

On the other hand, if one studies the school as a social system, the role of the teacher, and the demands of mental health work, there are certain general aspects in child management which tend to recur in most schools, although the form and shape may differ in suburbia and central city. A school mental health consultant is effective only if he has considerable armament at his disposal and at the same time comes to a particular school with humility, knowing he will learn more than he teaches. The only preknown aspect is that the program will require a great deal of brain work to do the kind of diagnostic assessment in total planning which school mental health demands.

REFERENCES

Allinsmith, W., & Goethals, G. W. *The role of schools in mental health.* New York: Basic Books, 1962.

Berlin, I. N. Unrealities in teacher education. *Sat. Rev.*, 1964, 47, 56-58.

Coleman, J. S. *Social climates in high schools.* Cooperative Res. Monogr. No. 4. Washington, D.C.: U.S. Dept. of H.E.W., Office of Education, OE 33016, 1961.

Cutler, R. L., & McNeil, E. B. *Mental health consultation in schools.* Dept. of Psychol., Univer. of Michigan (no date).

Gump, P., & Sutton-Smith, B. Activity setting and social intervention. *Amer. J. Orthopsychiat.*, 1955, *25*, 755-760.

Ketcham, W. A., & Morse, W. G. *Dimensions of children's social and psychological development related to school achievement.* Cooperative Research Project 1286, USUE, Univer. of Michigan, 1965.

Kipfer, J. F. *School mental health.* Detroit: Michigan Society for Mental Health, 1959.

McNeil, E. B., Cutler, R. L., & Morse, W. C. The school mental health program. In M. G. Gottsegen & G. B. Gottsegen (Eds.), *Professional school psychology.* Vol. 2. New York: Grune & Stratton, 1963. Pp. 102-123.

Morse, W. C. A research evaluation of an action approach to mental health. *Amer. J. Orthopsychiat.*, 1961, *31*, 324-331.

Morse, W. C. The crisis teacher public school provision for the disturbed pupil. *Sch. of Educ. Bull.*, 1962, 37, 101-104.

Morse, W. C. The mental hygiene viewpoint on school discipline. *High School J.*, 1965, 47, 396-401.

Ojemann, R. H. *Developing a program for education in human behavior.* Iowa City: State University of Iowa, 1959.

Redl, F. The concept of therapeutic milieu. *Amer. J. Orthopsychiat.*, 1959, 29, 721-727. (a)

Redl, F. Strategy and techniques of the life space interview. *Amer. J. Orthopsychiat.*, 1959, 29, 1-18. (b)

16

THE ST. LOUIS SCHOOL MENTAL HEALTH PROJECT: HISTORY AND EVALUATION

Margaret C.-L. Gildea, John C. Gliaewell, and Mildred B. Kantor

St. Louis County Mental Health Department

HISTORY OF SERVICE

The school mental health services with which this paper is concerned (Gildea, 1959) began in the city of St. Louis in 1947 and were started in St. Louis County under the auspices of the St. Louis County Health Department in 1951. The research project for evaluation, reported in the second section of this chapter, was conducted in the St. Louis County Health Department, financed by the National Institute of Mental Health.[1]

In the city of St. Louis, in 1947, there was an active organization of educators and lay people called The St. Louis Council for Parent Education. This group had originally come together for the purpose of developing programs to help parents understand the problems in raising and educating children. The social disruption following the war and concern about delinquency and behavior problems generally had given impetus to the movement. Initially this group had set up lectures and institutes in which experts told the audience what was wrong and how to correct it. Gradually it became apparent that those listening were already familiar with the material and that, in fact, the same middle- and upper-class groups gathered together, talking mainly to each other.

Therefore the group began looking for a new project in an attempt to reach out to parents who were so far uninvolved. The leader in developing the new activity was a school principal with a long personal and family background in the St. Louis German liberal education tradition. She particularly wanted help for the school parents in the lower middle-class and lower-class areas where she and some of her colleagues were working. These particular schools, in which the pilot project was introduced, were segregated white schools in well-settled old parts of the city. The principals were enthusiastic about a proposed school mental health project, and the superintendent and board were accepting, so long as financing was arranged from outside and budgetary problems not brought up.

---

[1] Research Grant M-592 from the National Institute of Mental Health of the National Institutes of Health, United States Public Health Service.

Meanwhile a renewed interest in group therapy among psychiatrists and the allied professions was developing. The American Orthopsychiatric Association had spearheaded this interest in using group methods for treating children with problems and their parents (Amster, 1944; Slavson, 1943). Using this technique the consulting professional staff of the council developed a project of group therapy for parents of children with behavior problems in public schools.

The program was set up to employ a psychiatric social worker half-time to work in two schools, or about one-fourth time in each school of five to six hundred children. This was a concentration of social work time that had never been equaled in public schools of this area, and doubtless some of the social worker's success was due to this fact alone. Many other favorable factors entered into his considerable success, such as warm relations between him and the principals, his own friendly unpressured personality, and his expertise. Viewed along many dimensions, this pilot project was an unqualified success. Cooperation during its course was excellent, and there was a noteworthy absence of complaints by participants. The services provided received enthusiastic acceptance by school personnel and parents, and requests were received for expansion of the programs into new schools. A fuller account of the reactions to this project has been presented elsewhere (Gildea, 1959). It is sufficient here to note that this initial success led to a strong drive to develop and expand the program.

This new work was directed primarily to the parents. Teachers selected children with behavior problems or emotional maladjustment from each grade, and their parents were invited to meet the social worker. He then invited the parents whom he thought suitable to weekly group meetings. These were group therapy sessions—informal, sociable, and accompanied by coffee and cake. The children themselves were not seen by the worker, and the teachers were seen only in referral interviews or informally.

In reporting the development of subject matter in the groups the worker observed that the parents invariably began their participation by expressing resentment against the school, its personnel, or society. They disclaimed responsibility for the child's problems and laid the blame elsewhere. Gradually, through discussion, each mother came to see what she could do to improve matters and began to be able to accept responsibility for the climate in her home. This change in attitude was usually associated with an improvement in the child's behavior as judged by the teacher. Thus the importance of maternal attitudes emerged, especially the attitude relating to responsibility for the child's behavior. This influenced much of the subsequent work.

The success of this program led into a wider development in the next several years in the city of St. Louis, and several other schools were involved, using a variety of workers. Another white social worker attempted to organize mothers' groups in a segregated Negro school. This effort met with failure and rejection. The school personnel, all Negro, were not accepting or responsive; and the mothers, in their own courteous way, rejected the service. This same worker was successful in another white school. A well-trained Negro social worker also tried to get Negro school mothers' groups together, but also failed. She was more successful than the white worker, however, in her individual casework contacts with the Negro mothers.

Other experiences in different settings showed that a variety of workers could be successful. In one case the worker was a woman psychologist at the master's degree level. In another, the worker was a nonprofessional woman who had grown children and whose education included a B.A., but no formal graduate training. She did very well in the school, consultation and group therapy work. This experience led to the wider use of volunteers, nonprofessionals, or lay people, in the lay-education program.

During the development of the group therapy program it became apparent to the people involved that the success of the service in each school setting hinged on several factors; but most prominent among them was the general level of understanding and acceptance of mental health concepts within the community comprising the school area, both parents and teachers. The failure of the program in the Negro schools brought home to the board members and the workers, with particular force, the necessity of a general mental health education program.

At about this time the St. Louis Council for Parent Education merged with the Mental Hygiene Society. The resulting group, the St. Louis Mental Health Association, became particularly interested in mental health education. An active group of volunteers came together and developed a program of group discussions, led by each other, centering around ideas presented in the new mental health films.

Previous experience of exhibiting these films at board meetings had demonstrated that they created considerable anxiety when they were shown alone. In most cases spontaneous discussion following the film quickly reduced this anxiety to manageable proportions, in addition to emphasizing and underscoring the points that had been made. In fact, discussion often seemed to lead to enthusiastic acceptance of the ideas presented.

Thus a program of discussion groups led by lay leaders was developed. These leaders were trained in a series of workshops conducted by professionals, a psychiatrist and a psychiatric social worker, and held in the Association offices. At first the participants were chiefly board members and their friends, largely self-selected. Later an effort was made to screen the applicants, but it was generally held that anyone who wanted to could lead a discussion. The process of self-selection went on during the training period, and later, too. For instance, a workshop might start with thirty people and wind up with twenty who wanted to go ahead with it. The rest would have eliminated themselves. Some would drop out after leading a few discussions, feeling that they did not like it or were not suited to it. The workshops were three sessions of two hours each. The basic teaching was that discussion should arise from the group, that the role of the leaders was to keep discussion going and tension within manageable limits. The leaders were reminded that they were not experts and should not attempt to answer difficult or theoretical questions. The very fact that they were not experts was considered to have positive value in promoting the idea that in human relations there are no positive answers. The group seeks to find a useful point of view together.

Leaders were usually sent out to meetings in pairs, with a more experienced leader accompanied by a less experienced one. The groups were most often held in schools, PTAs, and mothers' clubs, but some were also held in churches, before service clubs, and wherever else they were requested. The Association had some 40 or 50 volunteer leaders on their panel, and frequently 20,000 people were involved in the groups during a year. Often the leaders requested follow-up workshops. These were regularly arranged in two-hour sessions with various professionals leading them.

There were, thus, two mental health services offered in the city of St. Louis: the school-centered group therapy for parents, and the educational discussion groups. As the group therapy program expanded, private financing became more difficult. The St. Louis Board of Education had a division which gave services to parents, and the privately financed services were discontinued in 1951.

At this time the Health Commissioner of St. Louis County became interested in school mental health, and especially in the project of group therapy for parents in the city schools. There had been a long tradition in the county in which various school districts contracted with the county Health Department for health services. The school mental health service became part of this structure. Initially the county Health Department offered a school mental health service to three school districts, for which they paid 75¢ per capita yearly. This was the same kind of arrangement under which these districts contracted for nursing and dentistry.

The financing arrangement changed after two years, and the service was paid for on the basis of $5 an hour for the worker in the school. This has now been increased to $7.50. The county Health Department pays the rest of the expense. The service program has now expanded into seven districts and has assumed a somewhat different character in each district to meet specific conditions and specific requests.

The expectation at the beginning of the services was that the program of group therapy for parents established in the county would be similar to that which had been developed in the city. This, however, was true to only a small degree. Differences between the two programs can be explained by different characteristics of the areas involved, as well as by central administrative features of the county Health Department and the local school districts.

The situation in the county contrasts with that in the city in many ways. In the city there is one superintendent of schools, who is firmly established, and the schools themselves are in well-settled neighborhoods. Traditionally the city schools are concerned with their neighborhood parents, who can easily walk to school and thus are familiar with the schools and their personnel. These parents are readily accessible to the school, and there was no problem getting them to come in. The county, on the other hand, is undergoing rapid growth and population expansion. Many of the school districts are made up largely of new subdivisions with very little social cohesion, or even inter- or intra-community transportation. In many districts, especially the newer ones, the school boards and their superintendents were uneasy about the parents, who are their electorate. This uneasiness seeped down to the principals and made all the school officials guarded and defensive about allowing workers to have direct contact with parents. Some of them felt that this kind of new program, coming from the outside (i.e., the Health Department), represented a potential threat to the school image in the eyes of the electorate; and it was particularly difficult in some of the districts to have free access to the parents. In several districts, even though the superintendents had voluntarily contracted for their services, the workers found it hard to give any because of lack of referrals. In some districts the guidance counselors blocked referrals. In at least one school a worker was given no place to interview except a boiler room or a broom closet.

Other factors which made access to the parents difficult were transportation, shortage of workers' time, and type of case referred. As mentioned above, there was little public transportation, especially in the evenings when meetings of parents were usually scheduled. However, parental participation was also difficult to obtain in schools serving upper-class or upper middle-class areas where transportation was no problem. The shortage of the workers' time made it impossible to make home visits for intake or follow-up. Further, in the early period at least, very difficult cases which were intrinsically untreatable in the school setting were referred. These cases usually required referral to a clinic or other facility; this absorbed all the available time.

Because seven different independent districts were involved in the county and because there was a considerable turnover in school mental health personnel, the programs developed in the various districts were not uniform. Workers were quite free to follow their individual interests if they had sympathetic school administrators. Thus, some of them conducted workshops and case-conferences for teachers. In a few schools, groups of classroom mothers, all invited, come in for discussion groups. Some of the workers used group therapy with groups of adolescents, and there were one or two ongoing groups of referred parents. However, the program in the schools has gradually developed into a casework service, and group therapy has played a minor role.

For similar reasons the lay discussion groups did not take hold in the particular schools in which the school mental health program was operating.

The program was going on actively elsewhere in the city and county, but it was not accepted well in the experimental schools. Although a number of discussions were scheduled and held, they were not well attended, as they usually were in the places that had actively requested them.

SUMMARY OF RESEARCH FINDINGS[2]

From the beginning, in 1947, evaluation of the group therapy program for parents of public school children who exhibited behavior symptoms was much talked about. It seemed at first that a follow-up interview of the teachers by the school worker himself would give a picture of the success or failure of the parent therapy groups. However, it soon became apparent that the teacher's report of the child's current condition was influenced to a marked degree by her transference feelings for the worker and by her general orientation toward the program and her principal who introduced it. These follow-up interviews showed that in the early school work 80% of the children whose parents participated in the group therapy were seen as improved in adjustment by the teachers, while about the same per cent of those whose parents did not participate were seen as unimproved (Gildea, 1959).

It appeared that objective results could not be expected from a worker's own follow-up, although this precept is not as widely accepted as one might think. Many well-known follow-up studies of treatment methods are done by the people involved in the treatment, or by others close to them. This factor accounts in part for the glowing results obtained in some drug studies, as well as in other treatment method follow-ups.

Recognizing this source of error, the group thought that counting the referrals of pupils from the studied school districts to the relevant police districts before and after the program would be a measure of its effectiveness in averting gross disturbance. But again, it was apparent too many variables were involved in this simple counting procedure. Therefore, with advice from the NIMH[3] a research program was developed in cooperation with social scientists.

In order to study the effectiveness of the two programs described in Section I, it was first necessary to develop methods of measuring the adjustment of children. Second, because it was felt that maternal attitudes strongly influence children's behavior and that improving these attitudes was one of the chief aims of these programs, it was necessary to conceive of ways of studying and quantifying these maternal attitudes. Reported below is an outline of parts of the research conceptualization. Inferences and conclusions selected for inclusion here are based on parts of the data collected. Much of the detail of data analyses has been already published in the cited references. Some is still in preparation for future publication.

---

[2] The authors acknowledge with gratitude the contributions of the following collaborators: Ivan N. Mensh, Ph.D., Herbert R. Domke, M.D., M. P. H. and A. D. Buchmueller, M.S.W.

[3] We acknowledge with gratitude the personal interest John Eberhard, Ph.D., and later Ronald Lippitt, Ph.D., took in this proposal.

ASSESSMENT OF LEVELS OF EMOTIONAL ADJUSTMENT OF CHILDREN

Determining ways of classifying the mental health of children was the first undertaking. A decision was reached to consider the child's general state of emotional well-being from the points of view of his teacher, his mother, and his classmates (Glidewell, Mensh, Domke, Gildea, & Buchmueller, 1957; Gildea, Glidewell, & Kantor, 1960).

Teachers were asked to grade the children on a 4-point rating scale, from normal to very disturbed, needing clinical help. In the small or pilot sample described below the children were also graded by professionals, the staff of the child guidance clinic. It was found that the teachers' ratings correlated highly with the opinions of professional workers. Indeed, in 80% of the cases there was exact numerical agreement between the ratings of the teachers and the ratings of the professionals.

The mothers' opinions of their children's emotional state were covered in a detailed questionnaire designed to collect data about family structure and social characteristics, as well as information about how the mother experienced and perceived her child. One of the ways this information was obtained was through a symptom checklist (Glidewell, Mensh, & Gildea, 1957; Glidewell, Gildea, Domke, & Kantor, 1959; Mensh, Kantor, Domke, Gildea, & Glidewell, 1959) accompanied by suitable probe questions for each symptom the mother reported in her child. This questioning collected data on the frequency, duration, and severity of the symptom and on the mother's attitudes toward the cause of the difficulty and how she thought it would probably come out.

In order to assess the classmates' views of each other, several instruments were used. The most valuable, in that it correlated with the mothers' and the teachers' opinions, was the sociometric questionnaire (Mensh & Glidewell, 1958). A semiprojective story completion instrument called "Secret Stories," and an adaptation of Rogers' use of a "Wishes" test were used. In addition, a most ingenious method of classroom observation called "The Bean Game," devised by Ronald Lippitt, was used. Data from the last three tests are still under analysis.

The Samples

Two groups of children and mothers were used in this research. The first, called the pilot study, or the small sample, was composed of 91 white public school children in the third grade of three different schools in St.

Louis County. These were schools contracting with the county Health Department for mental health services. This group of "normal" children had so few disturbed ones in it (only 6) that 35 children drawn from referrals to the St. Louis County Child Guidance Clinic were added in order to produce a broader spectrum for the pilot work.

The large study was composed of 30 third-grade classrooms in 15 contracting schools. These were divided into experimental and control classrooms. The study was repeated annually, three times, to determine change. The last repetition occurred 2½ years after the first. There were 830 families in the first year, but a marked degree of attrition occurred; by the end of the study, 2½ years later, only about half the children were left. About 25% had moved out of the classrooms, and thus out of the research, each year.

Findings Related to Mothers' Reports of Symptoms

One section of the questionnaire was devoted to asking mothers if their children had any of a list of 21 symptoms (see Table 1).

Table 1. The Twenty-one Areas of Difficulty Screened by a Symptom Inventory

1. Eating
2. Sleeping
3. Digestion
4. Getting along with children, withdrawn
5. Getting along with children, acting out
6. Getting along with grownups, withdrawn
7. Getting along with grownups, acting out
8. Unusual fears
9. Nervousness
10. Thumbsucking
11. Overactivity
12. Crying
13. Sex
14. Daydreaming
15. Temper tantrums
16. Lying
17. Stealing
18. Destructiveness
19. Rejection of School
20. Wetting
21. Speech

Sample Inventory Question

"Does Johnny have any trouble getting along with other children?"

A. "How often does he have this trouble?"
B. "How long has he had this trouble?"
C. "How serious is it?"

If a mother agreed that the child exhibited a particular symptom, she was asked about its duration, severity, and frequency. A number of interesting findings developed out of this symptom inquiry. The first was the question of the reliability of the mother's reporting. To determine this, a subsample of 184 mothers, who had had no contact with mental health resources during the intervening year, was drawn from the large sample that had responded to the questionnaire twice in successive years. It was found that 30% of the symptoms reported the first year were denied in the second interview as having ever occurred. The mother's reports about her child's symptoms were about 70% reliable from year to year on this special subsample (i.e., approximately 70% of the symptoms reported in a given year are again reported the following year).

On the large school sample of 830 white third-grade children, most mothers reported some symptoms. There was a regular relationship between the number of symptoms reported by the mother and the rating of adjustment given by the teacher. The children rated best adjusted averaged 1.7 symptoms, and those rated as needing clinical help were reported by their mothers as having three or more symptoms. There was no difference in numbers of symptoms reported for boys or girls, and there was no social class difference in symptom reporting by mothers.

In the large sample, containing very few seriously disturbed children, there was no increased differentiating effect found by using data reporting frequency, severity, and duration of the symptoms. In the small sample (in which about one-third were disturbed clinic children) the frequency, severity, and duration did increase the sensitivity. The mothers of these disturbed clinic children reported an average of six symptoms.

In the small pilot study it appeared that the symptoms correlating best with disturbance for boys were "sleeping trouble," "trouble getting along with other children," "nervousness," "unusual fears," and "stealing," while for girls "sleeping trouble," "lying," and "making a fuss about going to school" seemed to differentiate best. However, in the large school sample these findings disappeared, and the symptom that was most significant for both boys and girls was "trouble getting along with other children." This agrees well with the sociometric findings that demonstrated the schoolmates' ability to select disturbed children with a high degree of reliability.

As a screening tool, the mothers' reports of symptoms can be used with about 70% efficiency, which is about as good as any medical screening device (Glidewell, Domke, & Kantor, 1963). The extent of the agreement between mothers' reports of symptoms and teachers' ratings of adjustment of the children tends to increase as one goes up the social scale from lower class to upper class.

It is well known that teachers' reports of the level of adjustment of children shows a social class bias. There were no significant differences in numbers or types of symptoms reported by mothers representing the several socioeconomic strata. The teachers, however, in their ratings of levels of childrens' adjustment saw a significantly greater prevalence of disturbance in the upper- and lower-class children than in the middle-class children. It was found that upper-class mothers show a tendency to agree with the teachers about the emotional adjustment of their children. As an actual fact, in the St. Louis area upper-class children tend to be in private school, and therefore the ones that appear with their mothers in this sample from public schools are probably not typical. Lower-class mothers less often agree with teachers about disturbance in their children.

Middle-class children in our middle-class society probably show similar behavior at home and at school, and mothers and teachers tend to have similar attitudes toward their behavior. Therefore these mothers and teachers tend to agree about the children. Lower-class mothers reported more than the average number of symptoms for the total group of children rated well-adjusted by the teacher, and fewer symptoms for children rated as disturbed. Therefore in the lower classes there was least correlation between the number of symptoms reported and the teachers' ratings of adjustment. This is just another item in the enlarging body of evidence indicating the difficulty of really understanding lower-class phenomena. Communication is not to be taken for granted, and it is particularly difficult to know just where and when it has failed.

Findings Related to Sociometrics

The children were given a sheet with all the names of the pupils on it, in their correct seating position. They were asked to make six sets of judgments about their classmates. These were to identify which child they liked best, and which child they liked most to play with. Then they were asked which child they did not like, and which child they did not like to play with. Further they were asked which child asks them most often to do things they do not want to do, and correspondingly, which child does not ask them to do things they do not want to do. The last two questions were to elicit demandingness or bossiness. Analyses of these data showed the children's choices of each other remarkably in agreement with their parents' and their teachers' opinions (Mensh & Glidewell, 1958). The results correlated positively with findings in the mothers' symptom reports and the teachers' ratings. In the pilot study, where the children were rated by the professional staff of the child guidance clinic as well as by mothers and teachers, the children's choices of each other were found to be also significantly related to these workers' opinions. Sociometric analyses of the large sample confirmed these findings. The average correlation between teachers' ratings of children's adjustments in the large sample and sociometrics was .35.

Findings Related to Maternal Attitudes

In the study of maternal attitudes, two approaches were developed (Gildea et al., 1960; Glidewell, 1961). The first was a 17-item questionnaire stimulated by Shoben's (1949) work. In the pilot study of 126 mothers, 80 items were submitted, but only 13 of them showed a significant relationship to emotional disturbance in these children as determined by professional personnel (social workers, psychiatrists, and psychologists). Three more of the items showed a positive trend, and one (whether mothers thought they had more fun than children) was added. Thus, 17 items were compiled for the final test form. These are presented in Table 2.

Table 2. Maternal Attitudes Scales

TEST ITEMS	CONTENT AREA
1. Problems in children come out of trouble inside the family.	Responsibility
2. Children have more fun than grownups do.	Unclassified
3. It is hard to know when to make a rule and stick by it.	Discipline
4. Jealousy is just a sign of selfishness in children.	Rejection
5. School is a hard place for children to get along in.	Unclassified
6. Parents who are strict with their children know ahead of time what their children will do and what they won't do.	Discipline
7. It is hard to know what healthy sex ideas are.	Uncertainty
8. When neighbors or teachers complain about the behavior of a child, this shows that the parents haven't done a good job.	Responsibility
9. It is hard to know what to do when a child is afraid of something that won't hurt him.	Unclassified
10. It is hard to know what healthy sex play is.	Uncertainty
11. Children don't try to understand their parents.	Rejection
12. No matter what parents try to do, there are children who don't change at all in the way they behave.	Responsibility
13. The most important thing children should learn is obedience to their parents.	Discipline
14. It is hard to know when to let boys and girls play together where they can't be seen.	Uncertainty
15. When they can't have their own way, children try to get around the parents some other way.	Rejection
16. It is hard to know when I am forcing my child to be different from other children.	Discipline
17. Children should not bother their parents with petty problems.	Rejection

Contrary to the findings in the mothers' reporting of symptoms (in which there was 30% unreliability in their reporting), there was found here a high degree of stability of responses in the total sample. Answers repeated three times in 2½ years were highly consistent. The stability of these responses was social-class related; the higher the social class of the respondent, the more consistent were her responses.

It was found that most of the 17 items were significantly related to social class. Generally, the higher social class mother tended to disagree with any statement. This might be interpreted as personal rejection of the interviewers, most of whom were youngish middle-class women. This possible reason for the finding was not tested, but the finding itself indicates that upper-class mothers are probably not as accepting of mental health programs as middle-class ones are.

The higher the social class of the mother, the greater is her tendency to believe that grownups have more fun than children do. Conversely, the lower the social class, the more strongly the mother feels that the children have more fun.

There were six items grouped as "hard to know" (3, 7, 9, 10, 14, 16). These items stated that it is "hard to know" how to deal with sex and discipline and other problems of raising children. Significant social class differences appeared in four of these (3, 7, 10, 14). The higher the social class of the mother, the more likely she is to believe that it is not hard to know what to do about child behavior.

None of the 17-attitude items correlated significantly with the teachers' ratings of the children's adjustment. When social class effects were removed, there were also no significant findings.

Some of the attitude items were more likely than others to relate significantly to disturbance as measured by the mother's reports of her child's symptoms. All four of the discipline items (3, 6, 13, 16) and two of the sex items (7, 10) were significant in this respect. Only one of four "rejection" items (15) and one of four "responsibility" items (1) were significant. In five of the six "hard to know" items (3, 7, 9, 10, 16) there were significant relationships found also.

In general it was found that favorable adjustment of the child was related to the mother's having a certain flexibility with regard to discipline, being sure how she was going to act in various situations, and accepting the child. The mothers who reported a high number of symptoms in the children did not see themselves as involved in the child's problems. They were anxious and uncertain about how they should act in regard to the various issues in bringing up children, and they rejected the child.

Of the three factors emerging from the factor analysis of the 17-item attitude scale, only the first was clearly identifiable. This was the one containing all six of the "hard to know" questions, and it appeared quite definitely to represent an "uncertainty" factor. None of the three factors correlated with emotional adjustment of the children, as measured by either teachers' ratings or mothers' reports of symptoms.

The professional staff agreed that the mothers' sense of responsibility for the children's welfare and adjustment was a most important element in the child's development. The clinical staff, especially, felt that a strong sense of responsibility for the child on the part of the mother correlated with good adjustment in the child. The work in the city schools seemed to have demonstrated this. In the pilot study it appeared that the mother's recognition that one or more clear causes of the problem was related to her concept of her responsibility, and her feeling that she was capable of doing something about it—that is, her potency in this regard. Therefore an open-ended questionnaire was developed investigating the mother's opinions about the cause of the symptom, whether or not she felt herself to be involved, what if anything she expected to do about it, and whether or not she expected to be successful.

In collecting these data the mother was asked, "What worries you most about your child?" "How do you think it is going to come out?" "What caused it?" "Are you planning to do anything about it?" and "Do you expect to be successful in dealing with the problem?"

It was found that the lowest disturbance rate (as reported by teachers) occurred in the group of mothers who said they had no worries about their children. Teachers' ratings agreed that these mothers actually had nothing to worry about, in four out of five cases. For those mothers who admitted some worry, the lowest disturbance rate (19%) was found in the children of mothers who thought the problem had several different causes, who felt that they were responsible in part at least, and who were able to do something about it. The sickest children were those of mothers who thought there were several reasons for the problem, but who thought they were not responsible for it and were unable to do anything about it. Fifty-four and five tenths per cent of these mothers' children were disturbed.

In summary, the 17-item questionnaire related more to social class than to adjustment of children, but the open-ended questionnaire related more to adjustment than to social class, although there were social class findings here too: the lower-class mothers felt less responsible and more helpless, and they projected blame more. They tended to be more paranoid. When upper-class mothers had disturbed children, they tended to feel responsible but impotent, that is, depressed.

Experimental Design

The problem of setting up an experimental design that would produce data on the effects of the two mental health programs together and separately, using suitable controls in order to eliminate extraneous influences, has been reported in detail (Glidewell et al., 1957). The basic problem was to compare the effects of three levels of operation of the school-centered mental health programs in St. Louis County:

1. A combined operation, school-centered mental health services offered by the professional worker of the health department plus the educational program offered by volunteers of the St. Louis Mental Health Association.
2. The volunteer education program alone, and
3. The controls, involving no mental health services.

In order to deal with the three levels of programs it was necessary to organize the sample into groups of three homogeneous experimental units in the same school. An attempt to do this failed even for schools in the same geographical areas, since none had more than two third grades. Therefore, classrooms were selected as the most workable experiment units. For purposes of this research pupils in a single school were assigned at random to each of two third-grade classrooms. This resulted in the desired homogeneity for the two classrooms. Because there were generally only two third-grade classrooms in each school, however, it became necessary to create a design permitting the assignment of three levels of the program, only two at a time. An incomplete block design was selected in order to separate the effects of the programs from the effects of extraneous variables.

Change Data

The 17-item attitude questionnaire was administered to the mothers once a year, making a total of three administrations in all. Teachers were also asked to rate the children annually three times. Each year a different teacher rated each child, as the children moved through third, fourth, and fifth grades, while the mothers for the most part remained the same.

There was no evidence that there was any difference in effect of the volunteer education program alone or in combination with the professional school-centered program; but as described in Section I, both programs were less intense than originally planned or predicted.

Over the three-year period the teachers' ratings indicated that they thought the children got worse, in both experimental and control classrooms, but more markedly in the experimental ones. Looked at from one point of view, this can be considered a rather favorable finding. It would seem to indicate that all the teachers were becoming more sensitive to the emotional adjustment of their children and so were reporting more evidence of disturbance. The ones who had some exposure to the school mental health program, however, moved farther in the direction of recognizing emotional ill health than the controls.

The mothers, on the other hand, thought all the children got better; and there was no important difference between the experimental and control schools. During the first and second years, in each interview response, the mothers reported a reduction of symptoms in their children. This was true in the second interval between tests, as well as in the first. This is some evidence that the symptom reduction is not an interview error caused by the mother's recognizing that the interview would be shorter if she denied symptoms. There was a social class finding here, too. Although children of all classes showed some diminution in symptomatology, middle-class children seemed to lose more symptoms faster than lower-class children. These findings are statistically significant. This loss of symptoms probably represents successful socialization of most children during the early school years, the prepubertal period. It is to be expected that middle-class children would be the most successful in this regard.

So far as changes in attitudes were concerned, taken overall, using the final or basic sample, there was no difference between the experimental and control groups in either measure of attitudes. The responses to the 17 items remained substantially unchanged. The attitudes measured by the open-ended questions, however, showed movement in the direction of the mothers' generally accepting more responsibility for their children's behavior and acquiring a greater sense of potency in coping with it; in other words, the mothers here showed a general improvement in attitude, in both experimental and control groups. This may reflect the generally beneficial effect of the questionnaire itself, administered three times by sympathetic women, or a general trend toward the acceptance of mental health education brought about by communication media in these years.

Although there was still no difference over the 2½-year period in the experimental and control groups, there was a small positive correlation between change in the mothers' reports of symptoms and change in their attitudes; that is, the mothers thought the children got better, and the examiners thought the mothers' attitudes improved.

COMMENT

1. The success or failure of community mental health services seems to hinge on a number of factors that have been vaguely apprehended, but not too clearly defined. There is a positive element that has to do with enthusiasm, both for the giving of services and the receiving of them. For instance, skilled workers who have an enthusiastic supporting board raising money for them can go into positively accepting schools and do an inspiring job with the problems of children and their parents. If there is any faltering of positive support, or especially any resistance or resentment in the recipient group, the job becomes infinitely more difficult.

2. There is an increasing body of direct and indirect evidence that mental health services have great difficulty surmounting the barriers set up by class distinctions.

3. The amount of time the worker has available to spend in the school is an important factor determining success or failure. In this study the most successful workers in group therapy spent one-fourth time in schools of 500 children; this was the maximum saturation available.

4. Continued strong leadership and close supervision are very important. For the best results, clinical and ancillary services should be available for easy referral. Thus the backlog of very difficult cases can be readily dealt with and more preventive and educational activities pursued.

5. In this kind of large-scale evaluative research project it is difficult to

maintain services throughout the study period identical with those in effect at the time the project was developed. It takes much more time and money to do this kind of study than is generally predicted, and it is difficult to keep the same service or research teams together as the analyses and reporting drag out.

6. No elaborate screening devices are necessary to select 70% of the emotionally disturbed children for special care. Teachers can do it alone. A clinic team plus teachers can select 90%.

7. As one goes down the social scale, one increasingly sees mothers who tend to feel impotent, to project more, to feel uncertain and somewhat paranoid. Language and communication between workers and clients become more difficult.

8. In the upper classes, mothers tend to disagree with questionnaire items. If they have problem children they feel responsible and impotent, i.e., depressed.

9. A feeling of helplessness, impotence, and projection of blame are the attitudes in mothers which are most unfavorable to their youngsters' mental health.

10. The most important individual symptom, reported by the mother, for distinguishing an emotionally disturbed youngster is "trouble getting along with other children," social maladjustment.

11. Mothers see their children as losing symptoms as they become better socially adapted at ages eight, nine, and ten.

12. Teachers who are exposed to a mental health program tend to see more disturbance in the youngsters during the same period.

13. Maternal attitudes toward child behavior improved slightly over the 2½-year period, but not in relation to any specific mental health program.

REFERENCES

Amster, F., Collective psychotherapy of mothers of emotionally disturbed children. *Amer. J. Orthopsychiat.*, 1944, *14*, 44-52.

Gildea, M. C.-L., *Community mental health*. Springfield, Ill.: Charles C Thomas, 1959.

Gildea, M. C.-L., Glidewell, J. C., & Kantor, M. B. Two approaches to the study of maternal attitudes. *Psychiat. Res. Rep.*, 1960, *13*, 182-206.

Glidewell, J. C. (Ed.), *Parental attitudes and child behavior*. Springfield, Ill.: Charles C Thomas, 1961.

Glidewell, J. C., Domke, H. R., & Kantor, M. B. Screening in schools for behavior disorders: Use of mothers' reports of symptoms. *J. Educ. Research*, 1963, *56*, 508-515.

Glidewell, J. C., Gildea, M. C.-L., Domke, H. R., & Kantor, M. B. Behavior symptoms in children and adjustment in public school. *Hum. Org.*, 1959, *18*, 123-130.

Glidewell, J. C., Mensh, I. N., Domke, H. R., Gildea, M. C.-L., & Buchmueller, A. D. Methods for community mental health research. *Amer. J. Orthopsychiat.*, 1957, 27, 38-54.

Glidewell, J. C., Mensh, I. N., & Gildea, M. C.-L., Behavior symptoms in children and degree of sickness. *Amer. J. Psychiat.*, 1957, *114*, 47-53.

Mensh, I. N., & Glidewell, J. C. Children's perceptions of relationships among their family and friends. *J. exp. Educ.*, 1958, 27, 65-71.

Mensh, I. N., Kantor, M. B., Domke, H. R., Gildea, M. C.-L., & Glidewell, J. C. Children's behavior symptoms and their relationships to school adjustment, sex and social class. *J. soc. Issues*, 1959, *15*, 8-15.

Shoben, E. J., Jr. The assessment of parental attitudes in relation to child adjustment. *Genet. Psychol. Monogr.*, 1949, 39, 101-148.

Slavson, S. R. *An introduction to group therapy*. New York: Commonwealth Fund, 1943.

17

SOME STRATEGIES IN MENTAL HEALTH CONSULTATION: A BRIEF DESCRIPTION OF A PROJECT AND SOME PRELIMINARY RESULTS[1]

Ira Iscoe, John Pierce-Jones, S. Thomas Friedman, and Loyce McGehearty
The University of Texas

INTRODUCTION

As the title of this book implies, emergent approaches to mental health are related to emergent problems of mental health. There was a time, not too far in the past, when early case finding and diagnosis were looked upon as the best approach to preventive mental health. Although this concept still has value, we are faced with the realities of mental health manpower shortages and the urgent need to experiment in the development of innovative techniques at all levels of prevention. Primary prevention implies creating conditions whereby more effective coping with the stresses of problems of living will presumably result in better mental health. It is a probabilistic approach rather than an absolute one. It recognizes, or at least should recognize, that there will always be problems of mental health and that the fostering of "constructive coping" will allow children, their parents, and their teachers to deal more effectively with "problems of living" as these arise in everyday life. The complexity of human behavior and the multicausal nature of mental illness would seem to mitigate against total prevention of emotional disturbance; nor, perhaps, would it be desirable to have within our grasp the means to produce such serenity or even apathy.

---

[1] The project described in this chapter is supported by the Interprofessional Research Commission on Pupil Personnel Services (IRCOPPS) from a grant from the National Institute of Mental Health (MH1428). The University of Texas Personnel Services Research Center, John Pierce-Jones, Director, Ira Iscoe, Associate Director, S. Thomas Friedman, Research Coordinator, and Loyce McGehearty, Coordinator of Consultants, was set up as one of four centers funded by IRCOPPS in 1963. The aim of the Commission is "to promote more effective pupil personnel services by providing through research a body of knowledge that will increase the effectiveness of all those collaborating to provide the total school learning experience; demonstrating different kinds of pupil services programs in order to determine those that are best for various sizes and types of communities; and conducting and stimulating research on preventive mental hygiene in an effort to foster desirable pupil growth."

The University of Texas project is funded to October 31, 1967, being a four-year project. Besides the project described in this chapter, the Personnel Services Research Center is conducting research in other areas concerned with students and school personnel.

The decreased incidence of tuberculosis was primarily due to the general improvement of living and working conditions rather than to the development of new methods of treatment of the disease itself. The necessary condition for tuberculosis, a specific bacterium, is endemic in the population. The sufficient condition for tuberculosis is a weakening of the body's ability to cope. Raising the general health of the populace has resulted in better resistance and a consequent reduction of tuberculosis. In a similar vein, anxiety and stress will always be with us. How these are handled is more important than their presence or absence.

During the school years a wide spectrum of behavior is displayed by children. This behavior is frequently classified according to the value system of the teacher. Some of it is labeled "bad," some of it "good," and a healthy residue is variously interpreted or ignored. There has been much written on how the school can serve to "screen out" children who need "help." But not much has been written on what would really happen if teachers were truly as sensitive to the indications of developing emotional problems as psychologists would wish them to be. How would these identified cases be treated? By conventional methods? Already child guidance centers, the supposed bastions of secondary prevention, are handicapped by long waiting lists which, although testifying to the existing need, also point to a technological lag in the rendering of effective services. In fact, the general record of success of our traditional approaches in child guidance clinics is only fair. Clearly, then, some new strategies are called for, especially if we are to make progress in true preventive approaches. This does not mean that the child as a child or an adult will not experience anxiety, frustration, and the like. It does imply that within the school system the child will have a heightened probability of being dealt with by persons who can place his problems in perspective and can deal with them in more effective ways than at present. Referral for treatment does not result in the child's being "dumped." He still remains a pupil in a class or a school and is dealt with by increasingly sophisticated teachers.

INFLUENCE OF TECHNOLOGICAL CHANGE

It has been said that more knowledge has been created in the last fifty years than since the dawn of recorded history and that we are just at the threshold of this geometric increase. Technological advances have resulted in a higher standard of living for most of our population. However, our increasing awareness of the culturally deprived underscores that, while on the whole America has grown more prosperous, we are still confronted with the dilemma of cumulative deficits in some areas of our educational system. In order to rectify this lamentable state of affairs some innovative programs have already been launched. Our society is now faced with the problem of laying the foundations for positive mental health and of developing an educational system that equips children both for participation in a technological world and for fuller utilization of their potential as human beings. How the new technology and the new concepts of space and time will affect children of the future can only be imagined. How, for example, will the child of tomorrow function in a world that will double in population? What changes in sex mores, in living habits, and in value orientations will take place? What will be the psychological stresses? No one can say for certain, but it is clear that there may be an increased cultural lag between the educational system and the child, unless the system is more fully able to comprehend the rapidly changing world of the child, his needs, stresses, and methods of coping.

THE SCHOOL AS A COMPETENT INSTITUTION

Schools have changed rapidly from their former primary orientation to fundamentals. There is an increasing awareness that learning has an emotional component; and there is at least a tacit recognition that classrooms, schools, and even school systems differ in their ability to meet the emotional needs of children. With the advent of automated devices of various sorts the teacher will be called upon to perform more and more in those areas where she is superior to a machine. One of these would appear to be the area of human relationships and sensitivity. The implication here is that a competent school builds up a repertoire of resources better able to cope effectively with the problems that arise in the classroom, on the playground, or in a meeting of the faculty. It further implies the increased secularization of mental health. A teacher, with a little help, can or should be a tremendous resource to a child with a problem. She does not have to act as a psychotherapist or a psychologist. She merely acts as a more competent teacher.

With the increasing secularization of mental health and with the avowed and serious mental health manpower shortage, what contributions to the school or the classroom may be made by mental health specialists? Traditional approaches involve the identification of children with problems and some sort of a decision as to whether "it is serious enough" to warrant psychiatric or psychological help. In this approach the psychologist traditionally has been the seer who, by virtue of his tests, tells the teacher or the principal something about the child. Without wishing to demean this process, and readily acknowledging its necessity in many cases, we must admit that giving the child a test many times serves largely to relieve the teacher's anxiety and stands as objective proof that the teacher did something for the child. It is also a call for help and a way of bringing disruptive behavior or school failure to the attention of the school administration. Other traditional approaches are equally geared to let the teacher, the principal, and, indeed, the school system "off the hook." If the mental health consultation relationship is one in which a psychiatrist or psychologist takes charge of a case and acknowledges the need for the referral, little is learned by the school or the teacher except that referral to a mental health specialist is perhaps the only way to deal with disruptive behavior or emotional problems in general.

Advances in education, especially in the process of learning, would seem to support the notion that learning is not entirely an intellectual process. There is a large emotional component. If this is so, and we believe it is, then there may come a time (or perhaps the time has already arrived) when teachers will be more concerned with emotional preconditions and processes that interfere with full learning and human development than with crises of human adjustment which may suddenly become manifest in the classroom. Not that the two are clearly separated but, in the gradual turning away from areas of pathology to areas of positive mental health, the ability of the teacher and the school system to encourage learning, inquiry, and creativity in addition to the acquisition of factual knowledge will be increasingly stressed. The strategy that this suggests is to consider mental health consultation as an aspect of in-service education designed to improve the skills of the teacher in relevant areas. More subtly, it seeks to encourage her use of the resources within the school and to support the development of needed resources should they be insufficient or absent. These resources need not be of the traditional variety. Indeed, the addition of another psychiatrist or psychologist to perform traditional functions may impede optimal utilization of the creative potential of the teacher or of the entire school system in dealing effectively with mental health problems (or, more broadly, with the everyday problems of living as they are manifested in a classroom or on the playground).

The implication is that care-givers such as teachers can, with a little help, deal with an increased spectrum of problems. There is no attempt to phase out the services of psychiatrists, psychologists, and social workers. Likewise the contribution of pupil personnel services, already functioning, is respected and, indeed, welcomed. The issue is simply one of bringing about a more effective utilization of the resources that are already there and of increasing communication between professional mental health workers and the schools. The strategic deployment of scarce resources such as psychiatrists dictates a change in role. The teacher is respected as a teacher and as a human being. When she asks for help, there is the implicit recognition that her usual approaches to the problem have not worked or that some underlying factor or factors are operative which handicap her in dealing effectively with the presenting problem. In attempting to "free her up" the mental health consultant, in the approach we have adopted, in essence "lives the problem" along with the teacher. He explores alternatives, he attempts clarification, and all the while, he asks himself what is preventing the teacher from taking a certain course of action or why has the teacher taken a particular approach to the problem.

The reader will recognize that this orientation is essentially the one advocated by Caplan (1956, 1959, 1963, 1964). With some modifications this has governed the approach to school personnel in the project reported here. We turn now to a description of that research. The intention is to give the reader a broad view of its purposes rather than a detailed description. An orientation to the schedule may be of assistance.

October, 1963-August, 1964—Staff project, construct instruments, train consultants, make arrangements for test batteries to be administered, general planning.
September-October, 1964—Test batteries to all personnel in twenty-eight schools.
October, 1964—Begin consultation service.
April, 1965—Readminister some selected scales, evaluate some aspects of program.
Fall, 1966—Readminister selected instruments, pick up fall battery on new personnel.
Spring, 1966—Administer instruments, evaluate consultation service via interviews.
Fall, 1966—November, 1968—Analyze data, write up project.

THE PROJECT

COOPERATION OF THE SCHOOLS

Working with one or two schools in a system is the usual procedure in mental health consultation research or demonstration projects. Difficulties in this way of proceeding are compounded when the research involves a prolonged association (two years) with two school systems (Northeast Independent School System, San Antonio, and Austin Independent School District) and where the type of service is novel and, therefore, potentially threatening. Sixteen schools in the Northeast District (eight experimental and eight control) and twelve schools in Austin (six experimental and six control) are involved.

A further complication is that school superintendents realistically ask what their systems are going to get out of participation in the project. Even if they are satisfied, school principals often ask why they have been chosen. In addition, there is the understandable difficulty of asking the entire personnel in fourteen control schools to submit themselves to rather lengthy batteries of tests. Finally, even if the superintendents and principals are agreed, how about the teachers?

Without going into all the details, suffice it to say that acceptance of the project by the superintendents of the school systems was the first step. Extensive meetings were held with the principals of the schools concerned (both experimental and control). Sometime later a meeting was held with all the teachers in those schools, during which the Director, the Associate Director, the Director of Research, and the project Coordinator gave individual presentations. These were held in April, 1964. The purpose of the research was explained, the various organizations supporting IRCOPPS were mentioned, and the role of the various staff members was described. It was emphasized that the purpose of the study was to evaluate the effectiveness of a particular kind of pupil service worker called a Child Behavior Consultant (CBC). The reactions of the teachers to these services were to provide the project with data for determining the usefulness of this type of consulting function. The purpose of the consultation service was to enable the teacher to utilize her ability as a teacher to the fullest degree. The belief was expressed that often a little work early in a child's schooling could help him to cope and to learn more effectively than could much more work later on. The means for selecting elementary schools were stressed. No pretense was made of having all the answers, but the belief was put forth that effective consultation could resolve some of the problems of children. The wholehearted involvement and cooperation of the teachers was solicited. They, in turn, were assured that all information would be handled confidentially, that neither the school administration nor the consultants would have access to the data gathered from them. Thus, the data would remain anonymous as far as the teachers as individuals were concerned. The reason for the control schools was explained: only in this way could the impact of consultation be assessed. The control schools were vital to the project even if they did not get any direct services from the consultants.

Some further description of the schools involved in the study would be helpful. The Northeast Independent School District is separate from the San Antonio school system, although located in the same city. Northeast is a relatively prosperous district with at least two schools having Mexican–American populations and a lesser percentage of Negroes. The San Antonio area itself possesses a concentration of Mexican–Americans well in excess of the 12%-15% found in the Texas population as a whole. One experimental and one control school, both with about equal Mexican–American student populations, were included in our study. The other schools in the study ranged from lower middle-class to upper middle-class status, and each of these was matched by a control school of comparable status.

In the Austin Independent School District a more heterogenous distribution of schools was available. Two Negro schools were included in the study. One of these schools could best be characterized as being mainly composed of children whose families were members of the "rising" middle class. The other Negro school was less affluent and more in the commonly perceived mold of Negro schools both in the South and in the North. For example, the orientation of the "rising" middle class school (and its control) was more toward achievement and middle-class values. In contrast, the principal of the less affluent Negro school spent more of his time on matters of subsistence, such as money for lunch and clothing, and dealing with the social pathology found in schools where there is a high degree of family breakup, working mothers, and low incomes. For this latter school a control was easily located. A Mexican–American school was included (plus its control). Primarily staffed by Anglo teachers, the reading level of most of the students is retarded, and attendance at PTA meetings is poor. The predominantly Mexican–American student population is handicapped by having to learn English as a second language, by the low income of their parents, and by an unfortunately high degree of alienation of both the children and their parents from the school. A lower-class school and its control were in a mixed area composed of roughly 50% Mexican–Americans and 50% Anglos with a small sprinkling of Negroes. The two other schools, bringing the total to six, were selected as representing a typical middle-class, somewhat suburban school, and a lower-class, largely white Anglo student population.

Despite the need for repeated administration of some of the test instruments, the general level of cooperation was excellent. We were especially fortunate in having been able to capitalize on previous good relationships with the two school systems involved. The Northeast School District and the Austin School District both cooperated at a level and extent that was exemplary.[2] It would be an act of denial to report that "bursts of static" did not arise during the course of the program. These were most prevalent when retesting times came around (Spring, 1965; Fall, 1965; Spring, 1966). These bursts were not widespread; they usually originated from one or two schools, experimental or control. What sparked the reactions is not entirely clear. With regard to the experimental schools one clear factor emerged—the better the relationship between consultant and principal, the less the static and the more prompt the completion of the test instruments. We also found that the control schools could not be ignored. The principals and teachers had to be contacted carefully before each readministration and their cooperation solicited.[3]

---

[2] Our appreciation is extended to Dr. Virgil Blossom, Superintendent of the Northeast School District, and to Dr. Irby Carruth, Superintendent of the Austin School District, in this regard.

[3] The untimely death of Dr. Blossom was indeed a loss to progressive and foresighted education throughout the country. His successor, Mr. Joseph Woods, has continued to provide the Northeast School District with leadership of the highest quality. His cooperation with the program has insured its success. Dr. Carruth of the Austin Independent School District is entirely supportive and has aided materially in the smoothness of data gathering in his school system.

TRAINING THE CHILD BEHAVIOR CONSULTANTS

The provision of mental health consultation to public schools is in itself no novelty. There is a reasonably long history of social workers, psychiatrists, and psychologists working more or less collaboratively with public schools. Their roles and functions have varied, depending on the situation. In some cases the equivalent of child guidance clinics have been set up within school systems. In others, psychiatric or psychological consultation about individual children or problems has been available to teachers. The type of consultation has varied from "Expert Advice, Casefinding," to an approach somewhat similar to what we have employed.

In setting up the present project there was understandable concern about who was to do the mental health consultation and where we were to find sufficiently trained personnel. In the conceptual scheme, consultation was viewed as the "input" designed to effect changes that would be reasonable. The adequacy of the "input" was therefore of vital concern. The answers were soon forthcoming. In the geographical area encompassed by the project (indeed in the whole Southwest) there were few if any persons trained in what is essentially a Caplanian orientation to mental health consultation. The few persons who had this orientation were, of course, not available for what amounted to token payment for one afternoon a week's work, including completion of lengthy forms at the end of each consultation day. Of necessity, then, graduate students in Educational Psychology and Psychology were selected to be trained as consultants. Most of these were enrolled in the School Psychology Training Program in the Department of Educational Psychology. All were Ph.D. candidates. The term "Child Behavior Consultant" was chosen in preference to "Mental Health Consultant." There were several reasons for this, including some negative connotations in regard to mental health on the part of some schools and communities and the thoroughly legitimate claim that the consultant would be dealing with child behavior. (Generally this turned out to be true, although the consultant-trainees, when they eventually started work, were quite amazed at the number of adult behavior problems with which they had to deal.)

How does a project go about training sufficient personnel to service fourteen schools on a half-a-day-a-week basis? In the Spring of 1964, a seminar on Mental Health Consultation was set up on a two- to three-hour per week basis. Reference works in consultation were assigned reading, and the first author assumed major responsibility for the seminar. Most of the students had, by this time in their training, received some theoretical background and practical experience in counseling or psychotherapy. A fundamental reorientation had to be effected in the students' view of being helpful. Their previous training, and indeed, the training of most psychologists, was more in line with the medical model involving one-to-one work with the client. In the orientation employed in their new type of training someone was interposed between the child and the consultant, namely the consultee, be it school teacher or principal or some other person in contact with the child.

In all types of training there is some faith on the part of the trainee that what he is being taught has value, that it really "works." This was not easy to accomplish with Child Behavior Consultant trainees. It was not that they were particularly resistant, but rather that this was a new experience for them. Heavy emphasis on the theory of crisis and techniques of crisis intervention helped make the conversion easier. All students were required to read in the area of the crisis concept, using sources such as Caplan (1955, 1961), Miller and Iscoe (1963), Gildea (1959), and Bindman, Helpern, Isaksen, Klein, Rosenblum, and Wolf (1964). There was considerable and understandable debate about whether crisis intervention was really anything more than superficial treatment. Gradually the students acquired the viewpoint that if a person could be helped in a crisis and could learn to cope with it more effectively, he would at least have one more arrow in his quiver.

There was considerable speculation on the part of the trainees as to what teachers would want to consult about. Numerous verbatim reports of consultation sessions were presented, all with the orientation that the consultee, in asking for the consultation at this particular time, was facing some sort of crisis. For example, why should an experienced teacher ask for a consultation on the status of a child's intelligence? The problem was not whether the teacher could accurately assess the child's potential (there were, after all, achievement tests and psychometric services available), but more fundamentally, how could this particular teacher tell the mother, who was the PTA president, that the child was retarded, and not simply a slow learner? Why should a new teacher ask for the consultant's help in disciplining a third grader? Was it because she didn't know how to impose discipline, or was the problem, more fundamentally, that as a new teacher, she was worried about being backed up by her principal in a situation where, with justification, she set firm limits for the child? Why should an experienced teacher constantly mention "His mother was in a mental hospital" in speaking to a consultant? Did she see signs of mental illness in the child's descriptive classroom behavior, or was there some other underlying factor?

Another area that caused considerable concern to the students was how to impart to the teachers the fact that the Child Behavior Consultant would not see the child and would only "see" behavior through the eyes of the teacher. This role reflects a radical departure from what is learned in traditional training. The questions most frequently asked by the trainees were "How can I tell the teacher anything about the child if I don't see him?" and "How can the teacher have any confidence in what I say if she keeps insisting that I should see the child for myself?" These were viewed as entirely reasonable questions, but also as questions that were indicative of the mounting anxiety of the trainees about their new role. It was pointed out that implicit in the consultant-consultee relationship is the faith of the consultant that what the teacher is telling him is the teacher's perception of the situation, and that all that he, the trainee, need be concerned with is this perception.

When the trainees finally started work in the Fall of 1964, the great majority of them reported attempts on the part of the teachers to get them to see a particular child. To their surprise the great majority of teachers never refused to use the consultant's service because "he did not see the child himself." To come to accept this view was part of the in-service education of the teachers. It carried within it the implicit assumption that the teacher would take primary responsibility for dealing with the child, with the consultant taking on a resource function.

There is, oftentimes, a large and unbridged gap between theory and practice. Despite a semester's intensive training and a few "dry runs," the trainees approached their initial assignments to the fourteen experimental schools with much trepidation. Added to this was the further stress of having student status, having to prepare for qualifying exams, to write dissertation proposals, and to meet other academic demands. Moreover, there was the necessity of each consultant filling out his Consultant Report Form. This form had to go through several revisions and encountered the usual resistance inherent in a "research plus service" function.

In order to reduce anxiety, the trainees were permitted virtually twenty-four hours access to their supervisor, and most of them utilized this privilege rather heavily during the first two or three afternoons that they worked. The first full group discussion session after the first week of consultation was not a happy one for most of the trainees. Some were resentful that they had not been received with open arms. Others were astounded that, in spite of extensive preparation on the part of the project directors with the teachers and principals, some principals and many teachers asked them "What are you here for?" or otherwise incorrectly interpreted their functions. One or two were left cooling their heels in the teachers' lounge or in the principal's office. All of them had been warned that each school would manipulate them according to its needs.[4] Despite these warnings, manipulation was interpreted as rejection.

One trainee, a female, felt so rejected that she vented profuse hostility on the principal and one of the teachers. It was difficult to convince trainees that it might be important "to be manipulated" and that, at the appropriate time, the trainee could control this manipulation. Another trainee consultant, fortunately a mature one, found himself attending a rather stormy meeting in the principal's office, facing two irate parents with the principal introducing him as a psychologist who "we have called in in order to help us with Jimmy." Students gradually learned that manipulation by principals or teachers is an integral aspect of the consultation process and, indeed, is something

[4] Gratitude is expressed to Gerald Caplan and Miss Charlotte Owens for pointing out the dynamics of being manipulated.

which could, ultimately, have beneficial consequences. It was not easy to have the students accept the dictum that, eventually, he who is manipulated becomes vital to the manipulator and thus acquires more control over the situation.

In the process of learning about psychotherapy a student acquires reinforcement somewhere along the line. An interpretation is made, the patient has some insight, and the therapist is delighted. Positive reinforcement did not take place immediately for the Child Behavior Consultants. Special pains were therefore taken to make predictions about what would happen in the various cases presented for group discussion, in hopes that this might increase feedback and gratification for the trainees. For example, in one case where the teacher was quite obviously using the consultant in order to convey her displeasure with the principal, a prediction was made that in the next session the teacher would actually focus on the problem of the child. This prediction was made on the basis of what the consultant had put into the interview, especially his remark that "sometimes it must be very difficult for well-motivated teachers not to receive the support they feel they deserve." Another prediction was made that the consultant-trainee would be left to cool his heels in that particular school for the next session, and several after that, until some real crisis arose in the school. True to the prediction, after some prolonged heel-cooling sessions during which the consultant enhanced his position by having lunch with teachers and talking to them informally in the lounge, the principal greeted him at the door and said, "We have all been waiting for you. We have a serious problem of a child who is a sex maniac; you have got to do something." This change of attitude came from a principal who had earlier announced that there were no problems in his school.

The locus of occurrence and time allocated for consultations created considerable shock for the fledgling consultant-trainees. On the basis of prior clinical experience, they were accustomed to isolated one-to-one situations, usually of an hour duration. Here they had to learn to talk to teachers in the hall or in a lounge, as well as in the privacy of a separate room. Thinking on one's feet is not taught in graduate schools. The trainees at first complained about having to conduct a consultation while walking to class with a teacher or standing in the hall. They soon became more proficient and were unanimous in deciding that consultation required more alertness and quick thinking than did psychotherapy.

After the first half-dozen meetings with various teachers, most of the consultants were able to strengthen their relationships with the particular schools in which they worked. Each consultant went about doing this in his own way, aided by discussion with supervisors. Some had lunch with teachers in the cafeteria; others made it a point to begin their consultation day by visiting with the principal. Still others established allies among the teachers. Acceptance increased rather rapidly in most schools. The weekly supervision meeting was still being supplemented by individual sessions involving trainees and supervisors. At this point it became obvious that there were important, and sometimes handicapping, blind spots in some of the trainees. Intensive effort was therefore exerted to loosen them up. For example, one trainee definitely disliked the school secretary, and their relationship reached the point where she was doing her best to sabotage his work. Another, a female, was unconsciously "dumping" most referrals by indicating to the teacher that "nothing much could be done about the case." Despite these pitfalls and despite some obvious errors on the part of some of the trainees (and their supervisor), by the Spring of 1965 trainees began to reach their full stride as consultants. Each worked according to his own style of operation. It also became apparent that each school had its own personality, exemplified most clearly by the behavior of the principal.

The Fall of 1965 marked the second year of providing child behavior consultation to the experimental schools. During the Spring of 1965 some new trainees were taken on (again from the same sources) in order to replace four of the consultants scheduled for graduation. Training of the new people was easier because of the experience gained with the first group and, more importantly, because of the support and informal instruction that experienced trainees could provide. Therefore, we approached the Fall of 1965 with a more seasoned group of consultants and with better trained novices. For one thing it was possible to present each trainee with a *Handbook for Child Behavior Consultants.* This contained some of the materials used in the training sessions 1964-1965, as well as some new materials. Further, we had begun to know our schools and could offer more direct guidance for avoiding pitfalls. Also, we had survived the year; the school system was used to us, and sufficient positive feeling had been generated in most of the recipients of consultation so that the consultants' entrée was easier.

In addition to the research report forms filled out by each consultant, they were, in the final year, required to write a fairly detailed description of the school with which they consulted. This involved such matters as: How does this school go about solving certain problems? How does the principal relate to the teachers? How does the school relate to the central administration? How much do parents control the decisions made by the school? Information derived from consultant responses to these and other questions are presently being analyzed.

INSTRUMENTS

A detailed description of the construction, rationale, validation, and factor analytic composition of all the instruments must of necessity await the final write-up of the project. The March, 1965, and 1966 reports to the Interprofessional Research Commission go into further detail (Pierce-Jones, Friedman, & Iscoe, 1964; Pierce-Jones, 1965; Pierce Jones, Iscoe, & Friedman, 1966). In this chapter, we will limit ourselves to a brief description of the main instruments employed.

1. Dimensions of Teachers Opinions (DOTO) Form 12c. Designed to measure teachers' orientation to child behavior, this 110-item scale was devised by comparing the responses of a large sample of elementary school teachers to those of 150 Fellows of the APA Division of Clinical, Counseling, School and Developmental Psychology. Factor analytic studies have been encouraging and have provided good evidence that the scale measures factors such as Need to Understand Behavior and Encourage Competence, and Concern for the Child's Emotional Well-Being. Examples of specific items (on a five point agree-disagree continuum) follow.

a. Hostility toward classmates may be a symptom of the child's hostility toward the teacher.

b. The slow learner achieves more when assigned only tasks which he can easily perform.

2. Autobiographical Data (Form 20a). This device covers the full range of the teachers' life history and present situation. It is objectively scoreable for all of its 77 items. So far some promising factors have emerged that would seem of relevance to the use, misuse, or nonuse of the consultation service. For example, Factor VII–Committment to teaching–and Factor X–Autonomy within family.

3. Need for Assistance Scale (Form 19a). This contains 50 items and is designed to identify the classes of problems which school personnel need help in managing, plus the strength of such needs. The respondent is asked to indicate on a five-point scale the extent to which he or she would seek assistance for the behavior described. The range extends from "would seek assistance *every time*" to "would *never* seek assistance." Examples of items follow.

a. A third-grade boy has come to class extremely upset several times, and you have heard that his home life is extremely disruptive.

b. The whole class left the room when the bell rang, but before you dismissed them.

c. A little girl uses some swear words out loud in front of the class.

4. Behavior Classification Checklist (Form 11B1). This 92-item scale is designed to determine what a child does in the classroom and how much it irritates the teacher. Examples of some of the items follow.

a. Cheats on tests.
b. Spells poorly.
c. Says "Everybody picks on me."
d. Asks to do assignment differently than given.

Besides eventually providing some sort of hierarchy of problems for which teachers need assistance, there is the possibility of being able to sort clusters of behavior and to relate these to the problems teachers bring up in consultation as well as to variables obtained from the other instruments.

5. Consultant Report Form (CRF). In the planning phase of the project (October, 1963-September, 1964) much attention was paid to how each consultant would report his contact with his consultee. The possibility of using narrative reports was considered. The decision to construct and utilize an objective reporting device was not an easy one to make, and certainly the form itself was not easy to construct. No doubt some of the poignant aspects of the consultant-consultee interactions were lost to us by deciding to use an objective rather than a narrative approach. However, the benefits, in our opinion, outweighed the liabilities. The need for a standardized method of data-gathering was dictated by the realization of the large number of interviews that would be scheduled and fed into a computer. Additionally, the reliability of raters had to be ascertained. The construction and availability of an objective reporting form allowed the investigators to determine how much agreement there was between two or more consultants judging the same interview with the consultee.

During the course of the two-year project arrangements were made for a floating consultant to accompany a regular consultant on his visits and to compare ratings. To be sure, the Consultant Reporting Form forced focusing on selected aspects of the consultation process with the possible loss of other aspects that would have been picked up by other means. All considered, however, the objectivity and susceptibility to quantification supports the use of a report form such as we have employed. Subsequent practice and actual use have brought about even better agreement. Since the CRF was the main instrument linking child-consultee and consultant, its full completion by the consultant was vital and necessitated the consultant's making sure that the child's name was spelled correctly, that the teacher and school were correctly identified, and that other pertinent data were recorded on the form. In subsequent consultations about the same case it was not necessary to gather all the data again. Only the child's and teacher's names were necessary. The form could therefore be completed more rapidly for second and succeeding interviews.

The seven-page CRF may be broken down into a number of sections:

a. Coordinates: Here are listed the client code (supplied by research section), the status of the consultee—i.e., teacher, principal, nurse, etc.—and other pertinent variables.

b. Client Demography: The usual demographic information including treatment status, in addition to the specific question: Is this child a problem to teachers as well? (1) No. (2) One other teacher. (3) Several others. (4) Problem to all. It is obvious that we were concerned here with the breadth of impact of a child's problem on the school.

c. Characteristics of the Interview: Here we included location of interview, such as hall, office, lounge; length of interview; type of consultation (composition); etc.

d. CBC–Consultee Interaction:

(1) Attitude toward CBC–Defensiveness
Low 1 2 3 4 5 6 7 8 9 High
(2) Emotional state of consultee
Unemotional 1 2 3 4 5 6 7 8 9 Emotional
(3) Introduces personal material
Minimum 1 2 3 4 5 6 7 8 9 Maximum

e. Origins and Approach to Case: Here we included source referral, as well as reason for referral at the present time.

f. Consultee-Client Relationship: Here the consultant completed 12 items intended to characterize this relationship. For example,

Consultee attitude toward client
Rejecting 1 2 3 4 5 6 7 8 9 Receptive

g. CBC Consultee Assessment: In many ways this section is the most important in the entire form. It calls for the judgment of the consultant about what is the real problem facing the teacher and for judgments regarding the appropriateness of the concern expressed by the teacher and the reality of the degree of responsibility which she is assuming for this particular situation. Finally, out of some 100 themes, the consultant had to select main and secondary ones most likely to characterize the difficulty accurately. An example would be: Teacher asking for support of consultant to carry out a decision already arrived at. Role threat to consultee by other teachers, principal, janitor, etc. Teacher is saying "I'm not sure what this behavior means–please help me understand and resolve my own uncertainties."

h. Way of Handling Case: How the consultant handled the problem. What did he say? Here, too, some 100 messages designed to deal with the theme were possible. The consultant did not use a message verbatim, but was required to list the one that best approximated his action. He also had to state his degree of confidence that an appointment would be kept by the consultee, if one were made. To do so accurately presumed that an assessment of the established relationship had been made.

In addition to the five instruments described above, a number of other instruments were utilized regularly. They were What is an Ideal Pupil (Torrance, 1964); The Child Attitude Survey administered at the beginning of the study and at the end of the academic year; Assessment of Consultation Service given to personnel at end of each year; and School and Community Survey administered at beginning and end of academic year. The Torrance Scale was included in order to compare the responses of the teachers in the present investigation to responses by teachers in other geographical areas and to determine whether there is any relationship between this test instrument and The Dimension of Teacher Opinions Scale and The Need for Assistance Scale. The Child Attitude Survey was used to survey attitudes of teachers in regard to aspects of child behavior and to determine whether these attitudes were in any way related to educational and background factors on the part of teachers and the use of consultation service. The Assessment of the Consultation Service was a questionnaire given to teachers in both experimental and control schools in order to determine how much they knew about the consultation service and how much they thought it had been used. In addition, it was used to determine how using or not using the consultation service affected the use of other special services provided by the schools such as visiting teachers, elementary school counselors, curriculum supervisors, and the like. The School and Community Survey was included in order to determine the teacher's perception of the interaction between her school and the community.

SOME QUESTIONS ASKED

The provision of mental health consultation for a two-year period is, in part, designed to produce certain changes in the behavior of the recipients. Moreover, it provides an opportunity for gathering data relevant to the consultation process itself. In broad scope there is a belief that the changes as measured by the various instruments will reflect movement of the respondents in the direction of increased competence and sophistication in the handling and understanding of the myriad of problems presented by elementary school children.

Even if no significant changes in the predicted direction were to occur on the project evaluation instruments, significant information could be obtained about various aspects and variables of consultation. If consultation is to be a viable mental health technique, then extensive study is called for. The following will give the reader some feel for the types of questions which are susceptible to research inquiry within the framework of the program that has been described.

1. What kind of children (i.e., sex, age, grade, family size, and type of problem) are the subject of consultation? What kinds of relationships exist among these variables?
2. Are there differences between the schools in number, type, and severity of problems and in use of consultation services?
3. Do different schools evaluate the consultation service differently?
4. Do experienced teachers utilize the service more or less frequently than inexperienced ones?
5. Do schools with predominantly Negro or Mexican-American students make differential use of the service? Do teachers in these schools bring up different problems than those in predominantly white schools?

6. What kinds of problems concern teachers the most? How are these problems related to various factors in the teacher's background, training, and test responses?

7. Does frequency of use of the consultant mean increased coping on the part of the teacher? Does she bring up different problems over a period of time? Does she persist with the same ones?

8. What are the characteristics of users of consultation services versus nonusers when such services are available? In comparable schools where consultation services are not available teachers who have problems with children make differential use of other resources provided by the school system. How do the nonusers of available consultation service compare in this respect? Do they make use of other services, or do they not make use of any resources?

9. How is child behavior consultation perceived by school personnel, relative to other services?

10. Where does consultation of the type provided fail to meet the needs of the school? What suggestions are there for improvement?

These are only some of the questions possible. Answers can be obtained by examination of the data system set up at the beginning of the project and added to as the research progressed.

The richness of the data plus the magnitude of the statistical task is amply reflected in the fact that in the fourteen experimental schools (as of 1964) there were 380 certified personnel to whom consultation was available. In addition to this, there were 389 personnel in the comparison schools who did not actually have the service available but whose responses to various scales and interviews are included in the data.

SOME PRELIMINARY FINDINGS

In a project which is both prolonged and involved and which still has a year to go there is an understandable reluctance to state any findings without the usual precautions about their being tentative, speculative, and subject to change. Some results have been given in the annual progress report to the Interprofessional Research Commission on Pupil Personnel Services (Pierce-Jones, 1965; Pierce-Jones et al., 1966). In the following pages, some salient preliminary findings known to us at the present time are summarized.

Equivalence of Personnel in Demonstration and Comparison Schools

Results indicate that either through careful matching of schools, luck, or random distribution of teachers, there were no significant differences when the program began between teachers in the demonstration versus control schools on the Dimension of Teacher Opinion Scale (DOTO), nor on the Behavior Classification Checklist. This is comforting in that it makes possible a relatively clean test of the effects of the consultation program on the various factors constituting these measures of teachers.

Extent of Use of CBCs

Up to February, 1965, some 600 consultations had been conducted. Of the 377 persons in the demonstration schools who were potential consultees, some 41% had actually used the CBC one or more times. There was some differential use by the school districts. Northeast School District in San Antonio showed 45% of potential consultees using the service compared to 36.6% in Austin. Whether this difference will continue remains to be seen. It may reflect our somewhat reinforced belief that certain minority group schools do not use CBCs the same way as other schools, both in frequency or type of consultation. Although the schools with predominantly Mexican-American populations in our study have Anglo-American principals and teachers.

The all-Negro school, by virtue of years of segregation, may have built up more resistance to accepting and using outside help than have schools with predominantly white Anglo or Mexican-American populations. While it is understandably too early to be definitive, the impression gained from the consultants assigned to these schools suggests more reserve on the part of the teachers and principal and more difficulty in gaining acceptance. This, of course, is a two-way street. It may well be that the consultants were not as comfortable in these schools. Furthermore, it takes a certain amount of security on the part of a school to refer problems to a consultant, and therefore only certain types of problems may be brought to the attention of the consultant. This limitation could well contribute to reductions in the frequency of use of the consultants. In the final analysis of data it will be possible to check carefully on some of these suggested variables and also to determine whether such factors as male versus female consultant affected frequency of use and type of referral.

Characteristics of Children Consulted About

Sex

Not surprising is the finding that roughly 70% of the children consulted about were boys. Fifty-four per cent of these boys had been subjects for consultation four or more times, while about 44% of the girls had this frequency.

Age and Grade

Approximately 56% of the children included in the total program have been about nine years old or younger. While about 55% of the children in the overall program have been in grades one through three, only 47% of those consulted about have been in these primary grades.

Degree of Pathology

About 34% of the children for whom there has been consultation have been judged by the CBCs to have moderate to severe handicaps. A scale developed by Bower (1959) contained in the CRF has been utilized as the basis for this judgment. The Bower Scale asks that children be rated on a 7-point continuum ranging from markedly disturbed psychotic children to those with normal problems of everyday living. Roughly two-thirds of the children consulted about have had only minor handicaps (1-3 on Bower Scale as we have used it). This finding may reflect a strong need for primary preventive work.

What Problems Are Presented?

A rough categorization of problems presented to the consultants indicates that 14% had to do with parent-child relations and other aspects of the home situation. Forty-five per cent can be classified as centered around concern about the child's emotional state, school motivation, or ability to learn. Fifteen per cent focus on the teacher's own professional uncertainty, while some 14% deal with the consultee's personal concern and anxieties. About 7% have to do with various kinds of role conflicts and interpersonal relationships.

If personal concern and anxieties plus role conflicts are indications of a less than smoothly functioning consultee, then roughly one in five of our consultees was asking for some form of help in the interpersonal areas. This may have some implication for understanding mental health problems of teachers as these may affect children. The addition of the 15% who expressed professional uncertainty produces roughly a third of the consultees who needed assistance in areas that could be closely related to their own adjustment. This figure, of course, may be inflated and will be compared to later data, including some breakdown into experienced versus relatively inexperienced consultants and their judgments.

Autobiographical Differences

An analysis of data on 119 teacher-consultees who used the CBCs at least once compared to those not using the CBCs' services available to them suggests that comparatively younger, less professionally experienced teachers from somewhat larger families tend to use consultation services with significantly greater frequency than their contrasting counterparts. They also tend to report poorer personal academic records than do nonconsultee teachers. There is, therefore, the suspicion, which must await further data for confirmation, that those teachers who use consulting services may be differentiated by a network of factors which make utilization of such service more attractive to them than to nonusers. It will be interesting to compare length of stay in the profession of the users of consultation as compared to nonusers.

There are a variety of other findings which are encouraging and which seem to indicate that the CBC service has an impact on the school and, indeed, the system.

Several of the principals took it upon themselves to write and express their appreciation for the help provided by the consultants. As an example of the wide range of involvement of consultants, one of these letters was written by a new principal who had the unenviable task of stepping into a school in midyear after the regular principal had been incapacitated. The consultant spent many hours with the new principal, calming his anxieties and acting as a valuable mental health resource. This was a prime example of the application of crisis principles. Although the consultant knew nothing about administrative procedures of the school, his support of the principal, in terms of helping him to recognize that the apparent resentment of the teachers and secretary might actually be a feeling of loyalty to the departed principal, eventually allowed for an effective transition. The principal was not hesitant in expressing his gratitude, claiming that "the consultant had made an extremely important contribution to the entire school." Rather significantly, during the month of crisis the graduate student-consultant was not fully aware of the immensity of the impact he was having. In a similar vein, many consultants have been startled by the expressions of gratitude on the part of teachers and principals. Not all of these expressions clearly define what the consultant did; they are rather confined to such statements as "he helped me so much," or "he told me just what to do and it worked out so well." With direct advice virtually taboo, it seems only reasonable that a subtle type of communication was working (as had been planned) which allowed the teacher to exercise her best judgment after the consultant had helped in clarifying the situation.

SOME IMPLICATIONS FOR THE FUTURE

The provision of mental health consultation services may be viewed as a type of "input." In the present project such services have some uniqueness in that they were provided, in the main, by graduate students on half-a-day basis per week, per school. They were one type among a variety of pupil personnel services provided by the schools. It is our belief that they did not conflict with, but rather complemented, other existing services. How well the purposes of the program have been accomplished remains to be seen in the final evaluation of our research data, which should be available in the foreseeable future. There is promise of some significant changes as measured by the various instruments we have described. Nonetheless, the practical minded psychologist and administrator may legitimately ask for further proof of the value of the service.

Suppose that our hoped-for changes occur at a highly significant level. Assume that child behavior consultation indeed makes teachers more tolerant, more supportive, better able to use resources, better able to deal effectively with types of behavior which they previously were unable to handle. Suppose, further, that interesting and cogent relationships are found between certain variables and the productive use of consultants. These data will be valuable per se; moreover it is highly probable that certain "styles" will be found in the use of consultants by schools and by individual teachers.

From the point of view of developing a competent institution, how well and how much of continued use of child behavior consultation will be encouraged by the schools? Recall, if you will, that the schools were receiving this service without the expenditure of funds. True, in both the experimental and control schools they contributed their personnel and required them to fill out rather lengthy questionnaires and forms. However, schools are always in a better position to contribute services rather than money. In terms of the future, how willing would the schools be to pay the salaries of Child Behavior Consultants (or variants thereof) on a full or part-time basis? If the efficacy of child behavior consultation is demonstrated, how willing would school systems be to assist in the reorientation of some of the present pupil personnel to the consultant's role? For example, could high school counselors be trained to function as consultants as well as counselors? Could retrained counselors and other personnel directly involved in special services maintain role clarity to the extent of encouraging teachers and the school to work on problems rather than moving in and taking over in the role of experts? Maintaining the consultant role in the face of increasing demands for direct service to children is understandably difficult, yet necessary, if this particular form of consultation is to achieve its goal. To those familiar with the internal organizations of school systems and the inevitable power struggles that exist in schools, as in other institutions, these questions are certainly germane. They point, in the long run, to the need for a reappraisal of most pupil personnel services and a possible reorientation. It is not that findings emanating from our project are likely to be revolutionary; but we are rather confident that they will indicate that the type of results obtained via child behavior consultation does bring about significant change in the attitude and behavior of teachers and other personnel.

There are no clear answers to the questions we have raised. There are, however, some encouraging signs. The superintendent of one of the school systems involved has raised the question of who will replace the consultants and has inquired about some sort of arrangements for next year. The elementary school counselors who have come in contact with the Child Behavior Consultants have generally been pleased with the assistance they have received and have profited from being oriented to this new role. This has been especially true for the recently appointed elementary school counselors supported by federal funds in schools catering to lower socioeconomic groups.

Since our research project is now completed, we do not have plans at present for the continuation of consultation services. There will, however, be systematic follow-up of teachers and pupils. This, alone, will not be sufficient to answer the main question, which, in its barest terms, boils down to the following: Assuming demonstration of the efficacy of this type of activity on a research basis, can it be translated into continuous support by the school system and the community? The matter is even more complicated by the fact that even if one or both of the school systems involved should be able to move toward budgetary support of a child behavior consultation program, it would probably not be possible at the present time to find the needed consultants.

Other questions, of course, arise. Would consultants be as well accepted and function as effectively if they were part of the central office of a given school district rather than outsiders who came in one afternoon a week? One advantage of using outsiders is that they are not enmeshed in the power structure of the administration. A teacher or a principal may, oftentimes, feel easier talking to an outsider than to someone linked to the administration. However, if a school system took the outsider route, what agencies in the community would be available to service the consultation needs of the school system?

These are logistical questions which have implications for community mental health. Analysis of the problems noted seems to point to the need, in urban areas, for closer relationships between child guidance centers, social agencies, and schools. It would imply that new patterns in the delivery of mental health services have to emerge, and it also carries with it an implication of the need for training a mental health consultant who may not be a Ph.D. Such a possibility is exciting in the sense of having within it the potential for providing an effective mental health resource via a mature housewife or a retired businessman. Properly trained, these persons might be able to perform effectively in a mental health-relevant situation. In this context it should be emphasized that one of the central aspects of the mental health consultation carried out in our program was that our consultants (and this was repeatedly underscored in their training) were not afraid to admit that they were puzzled by the problem or that they "didn't know," always adding that they would try to be of help anyway.

Since many of our Child Behavior Consultants are continuing their training in the area of School Psychology, it is our hope that, based on their experience, they will not be caught in the traditional activities of school psychologists. With mental health consultation in their armamentarium of skills, they should be able to devote an appreciable portion of their time to consultation with teachers. They should also be in a particularly favored posi-

6

tion to conduct in-service training programs with elementary school counselors, special skills teachers, and the like.

Although our research project was deliberately focused on, and limited to, the elementary schools, the implications for working with high school personnel, particularly counselors, have not escaped us. The role of the high school counselor, at least in Texas, is ambiguous and varies from system to system. It would seem to us that a reorientation of the high school counselor's role, both during his academic training and in in-service work, should eventually produce a counselor who is a capable mental health consultant as well as capable of performing the other duties presently required of a counselor.

In a book concerned with the emergent problems of mental health much excitement is generated; yet reason dictates the exercise of patience and an understanding of the fact that social systems are not easily changed. It is our hope that a modest demonstration of the positive impact of child behavior consultation services will add strength to the growing belief that pupil personnel services can foster significant primary and secondary preventive effects and that care-givers such as teachers can, indeed, be made more effective first-echelon mental health resources.

REFERENCES

Bindman, A. J., Helpern, J. M., Isaksen, H. L., Klein, H., Rosenblum, G., & Wolf, D. Roles and functions in school mental health, *J. Educ.,* Boston Univer. School of Educ., 1964, *146,* Whole No. 3.

Bower, E. M. *The emotionally handicapped child in the school.* Sacramento, Calif.: Calif. State Dept. of Educ., 1959.

Caplan, G. Mental health consultation in schools. In *The elements of a community mental health program.* New York: Milbank Memorial Fund, 1956. Pp. 77-85.

Caplan, G. *Concepts of mental health and consultation.* Washington: U.S. Children's Bureau, 1959.

Caplan, G. Types of mental health consultation. *Amer. J. Orthopsychiat.,* 1963, 33, 470-481.

Caplan, G. *Principles of preventive psychiatry.* New York: Basic Books, 1964.

Gildea, M. C.-L. *Community mental health.* Springfield, Ill.: Charles C Thomas, 1959.

Miller, K., & Iscoe, I. The concept of crisis: current status and mental health implications. *Hum. Org.* 1963, 22, 196-201.

Pierce-Jones, J. *Orientation to school mental health consultation research at the University of Texas.* A report to the Interprofessional Research Commission on Pupil Personnel Services. Austin, Texas (mimeo), 1965.

Pierce-Jones, J., Friedman, S. T., & Iscoe, I. *Annual report 63-64 to Interprofessional Research Commission on Pupil Personnel Services.* Univer. of Texas (mimeo), 1964.

Pierce-Jones, J., Iscoe, I., & Friedman, S. T. *Preliminary findings from child behavior consultation research at the University of Texas.* Report prepared for presentation to the Interprofessional Research Commission on Pupil Personnel Services. Austin, Texas (mimeo), 1966.

Torrance, E. P. *What is an ideal pupil.* Minneapolis: Bureau of Educational Research, Univer. of Minnesota, 1964.

18

EARLY IDENTIFICATION AND PREVENTION OF EMOTIONAL DISTURBANCE IN A PUBLIC SCHOOL

Melvin Zax and Emory L. Cowen
University of Rochester

INTRODUCTION

The program to be described has its roots in an earlier project, reported in some detail in several recent publications (Cowen, Izzo, Miles, Telschow, Trost, & Zax, 1963; Cowen, Zax, Izzo, & Trost, 1966a). In those reports some space was taken to justify a search for new approaches to problems of mental health in the light of society's growing awareness that emotional problems develop at a rate which far outstrips our capacity to train professionals to cope with them by traditional methods. The school was selected as an excellent focus for preventive efforts because so much of the young child's learning and socialization take place there and because important identification models are found there. Certainly the same and more might be said for the home; but for many practical considerations, such as geographical concentration, the availability of captive audiences, the likelihood of securing cooperation in experimental programs and assessment procedures, and the readiness for research that may have been engendered by ongoing contacts with mental health workers, children in the early school grades were selected as the target group for our efforts.

This earlier program conducted at School #33 in Rochester, New York, under the auspices of a research grant from the Division of Community Services of the New York State Department of Mental Hygiene attempted to deal with parents and teachers as well as children. The aspect of the original project directed toward the children involved both comprehensive evaluation of youngsters based on psychological testing, social work interviews with parents, and observation of behavior, not unlike that to be described below for the current project, and after-school activity groups. It was hoped that any beneficial effects of programs for parents and teachers would be at least of indirect benefit to the children.

The program for teachers had both a formal and a semiformal aspect. It included a series of five seminar-type meetings for primary-grade teachers, the topics of which were selected by the teachers themselves. These were organized and conducted by a school psychologist and a school social worker with full-time assignment to the school as a Mental Health Clinical Services (MHCS) team. In addition, six other meetings, led either by the MHCS team members or community specialists, were held for the entire faculty of the school. These meetings dealt with the following topics: the socioeconomic structure of their own school district, problems resulting from differing standards in the school and the community, the classroom application of mental hygiene principles, the effects of emotional deprivation, and mental health for teachers. In a less formal aspect of the program primary-grade teachers met aperiodically with MHCS team members as well as with a consulting psychiatrist to discuss individual problems and to exchange helpful information. Such meetings, in fact, took place quite frequently; and it was estimated that by the end of the school year, about one-third of the first-grade children had been brought up for consideration and discussion.

Parents of the primary-grade children in this experimental school were invited to a series of six evening meetings at the school. Each meeting was led by both a consultant of the Department of Parent Education of the Rochester Board of Education and the MHCS team members. Brief presentations on topics such as discipline, the changing roles of fathers and mothers, sex education, etc. were followed by a "buzz session" and discussion format. These coffee hours, as they were labeled, lasted approximately two and one-half hours each and were fairly well attended (i.e., from a minimum of 24 parents on a snowy midwinter night to a high of 70 parents from a grade totaling 110 youngsters).

The evaluations of the effects of the program (Cowen et al., 1963; Cowen et al., 1966a) revealed rather convincingly that children could be designated at the first-grade level as likely to experience later emotional problems and that, in fact, by the time they had reached third grade, these children were doing significantly less well as compared to others not so designated on a variety of indices measuring achievement, classroom adjustment, anxiety, and peer relationships. In addition, the total group in the experimental school was found to have less anxiety, as measured by the Children's Manifest Anxiety Scale (CMAS), superior achievement scores on report cards and standardized tests, and higher teacher and peer ratings than those in control schools. The most notable changes in parents and teachers alike were found in their attitudes toward mental health workers, who were seen in a more positive light after the program than before (Cowen et al., 1963; Cowen et al., 1966a).

In retrospect, it was felt that the results of the School #33 program were sufficiently encouraging to prompt expansion of our original activities. Particularly, it appeared that while the program which has been described had some salutary effects, it was largely oriented to the problem of early identification of ineffective functioning or emotional disorder rather than to prevention. We recognized that efforts in the latter direction would have to emphasize direct contact with children to a considerably greater extent, both in terms of interventive measures with early identified problem children and generalized impact on the total classroom situation. We wished, then, to move more actively in the direction of comprehensive and early secondary prevention. That being the case, further support was sought and obtained from the Community Services and Research Branch of the National Institute of Mental Health for a new five-year program emphasizing global preventive efforts, early detection of pathology, and concrete interventions of a secondary preventive nature. It is this program which will be described in the following pages.[1]

THE PRESENT PROGRAM

The basic design of the present program is similar in many ways to that developed in School #33. A school psychologist and a school social worker[2] have been assigned full time to the primary grades of a public elementary school, where they concern themselves, not with the traditional duties of such workers, but with developing a role aimed toward the early detection and prevention of emotional disturbance. This type of conceptual orientation is basic to our program and guides its "battle-line" implementation. Thus the mental health professionals attached to the project in the schools serve, perhaps first and foremost, as high-level resource people for the school principal, the teachers, the parents, and anyone else who might come into close interpersonal contact with the children (such as the volunteer groups to be described below). The efforts of the mental health clinical services team are augmented by those of a psychiatrist[3] who consults with them on a biweekly basis. Before presenting a more detailed account of the specific functions of the mental health clinical services team (the preventive staff) in the school setting it would be well to provide a brief discussion of the choice of a site for the program.

THE SELECTION OF A SCHOOL

Since the program is an experimental one with a considerable investment of time, energy, and money, it was felt that care should be taken to select a school where circumstances were not unfavorable to its optimal execution. The factors which seemed particularly crucial at the outset were few in number. First, a school which had relatively little pupil turnover was preferred, and this required focusing on a relatively stable residential neighborhood. This seemed important since the program was to be tested on children who would be exposed to it for a lengthy period of time and, equally important, follow-up studies of program effects were planned at various intervals after children had been exposed. Second, it seemed desirable to avoid, for the time being, the setting up of a program in a school which was receiving large numbers of children from remote neighborhoods in connection with an operational community plan for racial integration in the schools. This seemed advisable since the "open enrollees" would not be in a position to take part in after-school phases of program and their parents would be limited in their availability for participation. Finally, a school which had an administration that was not unreceptive to an experimental program such as ours was sought. It was felt that until the mental health roles that were being developed were well delineated and their worth demonstrated, many school administrators might well look upon such a project as a burdensome nuisance. To the extent that this were the case, such attitudes could defeat its purpose early.

---

[1] The project to be described was supported by NIMH grant MH-01500.

[2] Louis D. Izzo, M.A., psychologist and Mary Ann Trost, M.S., social worker.

[3] Angelo Madonia, M.D.

Parenthetically, it was also hoped that the experimental school would have little teacher turnover and high teacher receptivity to the project, but it was recognized that this was nearly impossible to predict beforehand. Some mild concern was also harbored over the possibility that the ideal school might have few children with evident or incipient emotional difficulties. This fear was quickly dispelled by experienced school mental health workers who had found no dearth of such problems in any of the schools of the Rochester system.

The elementary school that was ultimately selected as the site of the program was a relatively small, fifty-three year-old school in a predominantly white, largely older residential neighborhood that ranges widely in quality from middle class through upper and lower-lower class. It had a total of approximately 70 first graders, 55 second graders, and 60 third graders. The principal of this school appeared to be receptive to the establishment of an early detection and prevention program and seemed to display an appreciable understanding of its potential benefits.

DUTIES OF THE MENTAL HEALTH CLINICAL SERVICES TEAM

EARLY DETECTION

The earliest task to which the school social worker and school psychologist devote themselves is the detection, among first graders, of children who are either already displaying emotional problems or seem to have considerable potential for this. This detection procedure involves two phases: one conducted by the school psychologist and the other by the school social worker. These are described below.

Psychological Evaluation

Under ordinary circumstances, formal testing of children in the Rochester City School District does not start before third grade. In the interest of furthering early identification of manifest or incipient emotional problems, a diagnostic battery was developed for administration to first-grade youngsters, shortly after the start of the school year. This evaluation, conducted by the project psychologist with the help of the classroom teacher, is given to the children in small groups of 10-15. It includes the California Test of Mental Maturity and the Goodenough Draw-A-Man test. To these formal results, the psychologist adds his actual behavioral observations and the teacher provides an ability estimate, based on a six-point scale, the composite constituting a preliminary estimate of the child's intellectual potential and emotional status. The social worker is apprised of these findings prior to her interview with first-grade mothers, and wherever relevant, the information is transmitted to other school personnel.

Parent Interviews

The school social worker (SSW) holds approximately one-hour interviews with the mothers of all first graders at the earliest possible time. These are directed toward the gathering of information regarding the youngster's ability, personality, and behavior as well as the mother's interests and attitudes.

Before the interview takes place, the SSW has familiarized herself with all available data relevant to the child—his school history, his test results, and reports based on actual behavioral observations. Wherever specific follow-up based on any of these data is suggested, she is prepared to carry it out. The interview is structured as part of a routine procedure for getting better acquainted and as a reflection of the continuing interest of the school and the project team in the child and his family. Its purposes are to elicit pertinent background information about the child and his family situation, to help develop an image of the school as an interested institution, to help provide a clearer picture of the educational role of the school and the functions of the project staff, and finally, to formulate some casework impressions.

More specifically the SSW inquires into most of the following substantive areas: developmental and health history; adaptation to childhood training experiences and family practices in these matters; child's adjustment to playmates and to his immediate community; parents' evaluation of the child's functioning at home, school, and in the neighborhood; data relevant to the parents' own education and employment history; parent attitudes in key areas such as sex, sex education, parental roles, goals and aspirations, religious orientation, etc.

The SSW's impressions are summarized in the child's confidential project folder, as are specific notations of unusual or poor prognostic indicators. Based upon these data as well as on the prior cumulated record, when emotional difficulties are already manifest or incipient difficulties are judged to be probable, the child's folder is clipped with a Red Tag, so indicating. To this point this judgment has been a largely clinical one rendered jointly by the project psychologist and social worker. Attempts at more specific quantification of the elements contributing to the categorization are currently well underway.

PREVENTIVE FEATURES

The preventive aspects of the school program are directed toward school personnel, pupils, and parents. Again, the primary responsibility for coordinating these efforts falls to the mental health clinical services team, but outside resources in the form of a consulting psychiatrist, two clinical psychologists, two different types of volunteer groups, and other professionals are utilized in carrying out the program.

The program itself may best be described by focusing on those aspects of it which are directed toward the children. In the course of so doing, it will, hopefully, become clearer how the teachers are drawn into the program as well.

THE TEACHER AIDE (TA) PROGRAM

A unique feature of the present program is the attempt that has been made to reach the child at school by recruiting and training a group of housewives as mental health aides and placing them in the school for part of each day. Several operating models, including location of the aide inside and outside the class, have been explored over a two-year period. In either instance the rationale for this type of development resides in the oft-noted fact that certain children seem to need more of a teacher's attention than she can give them without seriously depriving the rest of her class. It was felt that many such children could be helped to adapt to the requirements of group participation and, indeed, to specific academic demands if there were a warm, interested human being available with the time, inclination, and experiential background to minister to their emotional needs as they arose.

Furthermore, it was felt that a great potential source of manpower (actually womanpower) for fulfilling such a function was to be found in the community in the form of women who have successfully reared their own children to a point where they have much free time and a desire to apply themselves to some useful pursuit. (This argument is more fully developed in Rioch's chapter in the present volume.) Accordingly, a "Help Wanted" notice was distributed to members of a few local professional groups and to a few clergymen inviting them to describe the prospective school program to friends or acquaintances who they felt might be interested in and suitable for such work. This notice stressed that we wanted volunteers who possessed a "personal warmth and liking for children, in connection with which the experience of having successfully reared children of their own would seem to be an important prerequisite." In addition, it was emphasized that the type of person we would be interested in should possess "flexibility, a genuine commitment to the work described, a life situation which would permit her to devote the necessary time to the project, and an interest in the school situation." Finally, it was indicated that the ideal volunteer should be free of major emotional problems and that the attributes described above would be valued above formal education.

This procedure afforded a type of screening which lightened the task of selecting those best suited to be aides. Most of the women who were attracted to the project from this source were thought to be quite suitable by the project directors and by the project psychologist, each of whom interviewed each applicant separately and rated her on a variety of characteristics. Even from these limited sources many more women expressed interest in participating than could be accommodated, suggesting that such a program might be feasible on a much wider scale than was possible within the framework of the present project.

Six teacher aide trainees, ranging in age from twenty-six to fifty-eight, were selected. None of these had a college degree, and one had not completed high school so that they ranged at least moderately in their educational attainment. All were seen as at least reasonably adequate mothers and were judged to be capable of relating well to children. At the same time, they appeared to have no great need to usurp or to be excessively critical of the teacher's role as an imparter of knowledge.

A five-week training program was developed for these Teacher Aides (TAs) which was not intended to provide them with a body of information but rather to assuage the feeling that they were being tossed into the arena with absolutely no tools for coping with what they would encounter. While, in point of fact, the experimenters were counting very heavily on the volunteers' personal qualities as their most potent resources, they felt the volunteers needed the intellectual and emotional support a training program might provide. Moreover, such training could serve to activate and catalyze a point of view, process, or way of thinking with respect to the emotional needs and problems of children. Accordingly, their training included academic-type materials on mental hygiene and concepts of prevention, personality development, and adjustment problems in children which, it was hoped, would convey an appreciation of such fundamental notions as psychic determinism and the importance of interpersonal experiences in the lives of children. This material was presented in a relatively simplified, discussion-oriented, issue-centered context directed primarily toward activating a particular way of thinking.

Another brief section of the training program was devoted to enlightening the TAs about the structure of the school system and the role-relationships therein, and to a brief, introductory survey of teaching methods. This material was presented by the school principal, the school psychologist, and the social worker. It was hoped that such content would help TAs better understand the teacher's role and provide a better understanding of the usual classroom routines. A third component of the training program may be termed "case material." This varied in nature from films such as "Unconscious Motivation" and "The Quiet One" followed by discussions, to classroom observations followed by discussions.

The early weeks of training were heavily loaded with didactic materials, while the later weeks placed a much heavier emphasis on case material. The later phases of training involved several sessions where TAs observed in several different classrooms and then discussed what they had seen with the school psychologist, the social worker, and the consulting child psychiatrist. These sessions allowed the TAs to become acclimated to the classroom and to begin to sense what useful purposes they might serve once they were actually incorporated into the class structure.

Ultimately, TAs met informally with the six teachers of the primary grades and were assigned to a classroom. Some efforts were made to match aides with teachers on the basis of the personalities of each, but these attempts were quite informal and more a product of the project personnel's compulsive natures than an act of great moment. The fact is that the project personnel had very little idea as to what criteria to apply in forming optimal pairings.

With training completed and assignments made for the initial year, TAs set up their own schedules; each arranged to spend one half of each school day in her assigned classroom, the choice of which half being left to her. One TA was assigned to each of the six primary-grade (first, second, third) level classes. Once the program got under way, arrangements were made for the TAs to meet as a group with the school psychologist and the social worker, their direct supervisors, on a weekly basis. In addition, the consulting psychiatrist attended about half of these meetings. The meetings were designed to allow the TAs to discuss their evolving relationships with both teachers and children and to air any problems that might be arising.

No attempt was made to prescribe a set of roles or functions for the TAs. The program was based on the assumption that each TA was a person with considerable assets and resources acquired by virtue of personality makeup and many years of "battle-line" experience. Hence, she should be allowed to operate in a manner consistent with her own spontaneous inclinations.

Quite frankly it was our view that the relationship between TA and child or children was more basic than the specific activity through which the relation happened to be expressed at any given time. Equally clear was the fact that the TA's role would have to be determined, in good measure, by her own personality, that of the teacher, and the interaction between the two.

In actual practice a variety of activities were undertaken by TAs, with different patterns becoming dominant in different classroom situations. Talking informally with individual children or small groups of children occurred very frequently, particularly so at times when the teacher was engaged in group activities with a segment of the class. Children came to talk freely and easily with the TAs who, from their point of view, blended readily into the classroom setting. Frequently, TAs would read, tell stories, or play games with the youngsters. On occasion, when a child seemed particularly incapable of profiting from the classroom activities, perhaps being disruptive to others, the TA would take him out of the classroom situation for a walk or to an unoccupied room in the building. Quite often TAs engaged directly in specific subject matter remedial work with youngsters requiring special help or attention. Here again, such work was done in the context of a warm and understanding relationship and with an eye toward the child's emotional as well as educational needs.

In principle, by her intensive work with the emotionally needy child, the TA not only contributed toward secondary preventive work with that child but also made some small contribution in a primary preventive direction by making the classroom situation an easier and more productive one for the teacher and the child's peers.

Aperiodic meetings were held with teachers before the actual inception of the TA program. Actually, each teacher volunteered to have a TA assigned to her class. In later teacher meetings, after the program started, it was hoped that they would express feelings engendered by the aide program, either positive or negative. The frequency of these meetings increased as teachers' experience with the aide program accumulated. At this time they began to voice many negative feelings, particularly about the nature of the roles which were evolving for aides and how this affected their own relationships with their classes. Specifically, they had begun to feel that TAs were becoming identified as "good mothers" in the sense that they neither defined nor set limits for the children. Thus, the latter role fell to the teacher, who at times felt she was being looked upon as an ogre. As a result of this problem as well as of others which indicated inadequate communication between TA and teacher, we believed that supervisory relations needed restructuring. The original setup, which has just been described, seemed to create two groups, TAs and teachers, who did not always feel they were working toward the same ends. It also seemed to have the effect of cementing allegiances to one's own group and thus prevented the coming together of TA and teacher in the way which was altogether necessary if they were to function as an effective team. We emerged from this experience with the feeling that a supervisory format which brings each teacher and her TA into regular contact with the school psychologist and the social worker should be created.

In a second year of work on this project the supervisory format and the way in which the TA functioned were altered. The TA was removed from the classroom, except for specific periods of time when, on invitation of the teacher, she entered to observe one or more children. During most of her time at the school, she was "stationed" in a room which served as the locus for a variety of interactions between her and the primary-grade children referred by teachers. The teachers, who strongly supported this revision in the program, used the TAs as resources to whom they could turn when a child presented any one of a variety of problems. These ranged from behavior which disrupted classroom routine through failure to benefit from the curriculum to withdrawal which seemed potentially damaging to a child's emotional adjustment.

The referral process brought teacher and TA together with members of the mental health team around the problem posed by a specific child. On the basis of the teacher's observations and other information possessed by the team, a concrete plan was worked out for the youngsters. The TA might then spend an hour a day, two or three times a week working with the child. Usually, the interaction focused on school work, but in many cases the major emphasis was on providing a relationship which supported the child emotionally and fostered better school adjustment. At times, and for a variety of reasons, the TAs worked with children in small groups. This group technique seemed quite promising with youngsters whose withdrawal, timidity, and undersocialization had made relating to their peers very difficult. Thus, in addition to receiving extra help with academic work, these youngsters were being given an opportunity to form relationships in a less complex and competitive setting than the classroom with peers who, in sharing a problem with them, were no doubt seen as less threatening than the average child. All of this took place under the close supervision and with the guiding encouragement of a warm and interested adult. TAs in this role were also in a position to cope with the inevitable and often transient crises which arise in children and which cannot be handled easily in the classroom.

One measure of the success of this form of the TA program is the fact that referrals mounted rapidly, so that a waiting list for TA time soon developed. Indeed, with a total primary-grade enrollment of nearly 200 youngsters, there were more than 40 referrals (20% of the group) to the TA program. Teachers seemed to find this outlet a very useful one for them. Relationships between teachers and TAs appeared to improve considerably as a function of the revision of the program; certainly so in terms of subjective reactions of members of both groups.

As part of the modification in program format, consultation was changed so as to involve jointly the project mental health professionals with both the teacher and TA concerned with a specific child (or children). The focus of this type of consultative-resource activity was oriented to the child and how best to meet his needs. This modified supervisory format reduced some of the sources of irritation of the prior format which inadvertently heightened isolation and opposition of teachers and TAs. Joint supervision around the child was very positively received. Indeed, it was regarded as so basic to the functioning of the program that a part-time substitute teacher was employed to relieve teachers who needed to leave their classrooms for periods of time to take part in supervisory conferences. It is likely that these meetings, in addition to assisting the teacher in dealing with the child, have begun to provide her with a viewpoint which will be found useful in dealing with other children as well. In other words, as the teacher works through a problem with one youngster, she acquires a psychological know-how which she can use with other children. In this way teacher education and sophistication in matters relevant to mental health have become an important focus of the project in a manner which, hopefully, may come increasingly to serve a primary preventive program.

THE AFTER-SCHOOL PROGRAM

A second major program introduced as part of our comprehensive effort at early secondary prevention with emotionally disturbed primary-grade children involved undergraduate volunteers from the University of Rochester who participated in an after-school day-care activities program. This program, like the TA one described above, has been in effect for two years. The first year's activities were undertaken primarily to develop a meaningful and useful working model. The initial pilot program was in effect for only two and one-half months (a period much shorter than that which we consider to be optimal); hence it is to be regarded primarily as an exercise in program development and "debugging" rather than as a basis for formal evaluation of substantive change in its participants.[4]

The target group for the after-school day-care program consisted of 17 primary-grade youngsters specifically designated by teachers, the project psychologist, and the project social worker as children who might, for one or another reason, profit from the type of interest and special attention that such a program could provide. The group included youngsters with acting out problems, problems of shyness and withdrawal, and failure in educational achievement. It also included several youngsters who, although they were not currently manifesting difficulties, seemed to be high-risk cases for the early future development of emotional problems.

---

[4] At the time of writing, we have completed a second year's experience with this program, involving a continuation of the model to be described, approximately the same numbers of child referrals and college student volunteers, and comparable research assessment. However, since data analyses for the second year are still in process, for present descriptive purposes the account will be limited to data from the initial year. The major difference in the programs is the length of their operation: two and a half months for the first year and six months for the second.

In actual fact, a total of 34 such youngsters were nominated for the after-school program. In each case a behavioral symptom checklist including an overall adjustment rating, an adjective checklist for personality attributes, and a prose referral statement containing a descriptive account of the child's principal difficulties was submitted by the referring person (usually the teacher). For purposes of a crude, prelimary evaluation, one-half of the total group was included in the program and became our experimental group. The remaining 17 youngsters, roughly matched with respect to the variables of age, sex, grade, and judged overall severity of problem, became a control group. In this case, the figure 17 represents the maximal number of student-volunteers that could be accommodated, given the limitations of supervisory time available for this purpose.

The original master plan for the after-school program was a relatively simple and straightforward one. A university undergraduate was to be assigned to a particular child, with whom he or she would spend about 70 minutes on each of two afternoons during the week. This was to be done within the confines of the school building and grounds, and participants were to be free to utilize most of the school's facilities (e.g., gymnasium, auditorium, playground, home economics room, shops, music room, cafeteria, etc.). It was felt that a variety of activities emphasizing expression, recreation, and/or academic work would provide suitable vehicles through which the undergraduate volunteer and child might interact. The overriding emphasis, however, was on the relationship to be developed between the volunteer and the child. It was hoped, particularly, that children in the program might benefit from having contact with an interested, energetic, enthusiastic young adult who would provide attention, at times affection, and, at the very least, a model of someone who was doing something constructive with his own life.

In addition to providing a meaningful relationship and beneficial experience for the emotionally disturbed child in need of such contact, this type of program, in principle, might contain the seed of some modest contribution to primary prevention. To maximize this likelihood, volunteers were sought from among elementary education majors in the College of Education at the University of Rochester. These represented people who were themselves about to become teachers and for whom an emotionally meaningful engagement in a mental health practicum exercise could, ultimately, have beneficial effects for many children.

The administrative staff of the College of Education concurred in the belief that an after-school program of the type described was of considerable potential value to the elementary education major. Accordingly, they were most cooperative in bringing the prospective program to the attention of their majors and agreed that participation in the program could be substituted for one of the classroom observation experiences in which the elementary education student ordinarily participates during the junior year. Eight elementary education majors volunteered for and were accepted into the program.

An additional 9 volunteers were needed, and these were obtained via a soliciting announcement made to the students of a large lecture section in abnormal psychology. A brief description of the prospective program was provided, with an indication that no more than 10 additional student volunteers could be accommodated. This notwithstanding, there were over 30 volunteers who were strongly interested in participating in the program.

All of the education majors and about 15 of the psychology students were interviewed, individually, by one of several advanced clinical psychology graduate students. Unlike the housewife volunteer program, our concern here was not to select for preconceived positive attributes. Rather the goal was to try to weed out the few students who seemed flagrantly maladjusted or grossly unsuited for the purposes of the program. Three prospective candidates were dropped for such indicators. Another 3 could not be taken on because their free hours did not match the scheduled program hours, leaving a total of 17 acceptable volunteers. Clearly, our screening was a gross one, and no attempt was made to prejudge what would make for an effective volunteer worker with very young children. Instead, the deliberate decision was made to allow a wide range of (nonovertly disturbed) types to enter the program in an effort to determine empirically those attributes which seemed to be most effective in actual practice. In retrospect, and at a grossly clinical level, it may turn out that some of the people prejudged to be less promising actually did very effective jobs.

After the final volunteer group had been constituted, the clinical psychologist directing the program met with them to discuss concepts of prevention, the underlying philosophy of the program, its objectives, and their place in the overall plan. Some possible ways in which the program might operate were considered; however, this was not overstructured and it was emphasized that the volunteer would have considerable freedom and latitude. In a subsequent meeting the volunteer group was taken to the school to go through the building, to become acquainted with the facilities and equipment that would be at its disposal, and to meet and talk with key school personnel.

The volunteers were encouraged to view themselves as neither therapists nor intellectualized dissectors of children's personalities. Indeed, an effort was made to withhold background and case material information on the assumption that this might foster an excessively "objective, case-historical" orientation.[5] Instead, our efforts were directed toward the encouragement of a spontaneous, warm, relaxed, "friend" relationship with the child, one which provided the youngster with a genuine interest by an adult, some additional individual attention, and a grown-up identification model.

---

[5] Experience during the initial year suggested that this concern might have been excessive. Additional background information pertaining particularly to the reasons for the child's referral to the program and his teacher's impressions of him was made available to volunteers during the second year.

Volunteers were assigned to children on a one-to-one basis; however, they tended to group in their play activities fairly often. Three groups of 5-7 volunteers were formed, each under the direct supervision of an advanced graduate student in clinical psychology who was himself under supervision of the clinical psychologist in charge of the program. Each group went to the school twice a week. Youngsters met their volunteers at a designated location in the school building when the school day was over, around 3:30 P.M. Activities went on until about 4:40 P.M. when the child left the school and returned to his home. Virtually the entire resources of the school were placed at the disposal of the group. Headquarters were located in the small cafeteria-playroom area, but children and volunteers were to be found, at varying times, in most of the special activity rooms in the school building.

Many different individual patterns of interaction emerged depending on the particular child, the volunteer, and the stage of the relationship. Some indication of the nature of these activities was obtained by having each volunteer fill out, three times during the course of the program, a type of process-analysis form summarizing how he (or she) and his assigned child spent their time together. Preliminary analysis of these data suggest that there were indeed marked variations as a function of (1) the specific volunteer-child configuration and (2) the stage of the relationship. Very grossly, and for the group as a whole, running around and cathartive physical activity occupied perhaps 15% of the time overall, but with a clear-cut decrease in frequency over time. Semiorganized play and organized play accounted for another 15% and 10% respectively. Controlled exploratory behavior represented another 7%-8% of the total time commitment, as did competitive table games. In the latter category there was, however, a sharp drop from approximately 15% at the first evaluation period to 5% at the last one. Noncompetitive table activities accounted for perhaps 12% of the total time, with a sharp increase from 8% to 18% between the initial and final measurement points. Artistic activities (painting, drawing, construction) represented some 8% of total time. Finally, talking and conversation (independent of other on-going activity) accounted for some 12% of total time, with very definite evidence of increasing frequency of occurrence over time. Recognizing, then, the tremendous range of variation, the foregoing summarizes globally the actual activity patterns for volunteers and children.

Upon completion of the afternoon's activity the volunteer group and the graduate student leader returned, each time, directly and in a single group, to the campus for a postmortem discussion session from 5-6 P.M. Here volunteers discussed specific children and the problems they presented, critical incidents which they had experienced, some of their own anxieties and concerns, and problems of technique and handling of children. These sessions provided an opportunity for the volunteers to learn around very recent, quite vivid, concrete, and emotionally impactful experiences they had had. Over time our experience suggested that the leader's optimal role was not that of a therapist; rather it was one of being an issue-centered discussion-oriented, contributing member of the group who sought to bring relevant problems to the surface with full respect for the volunteer's perceptivity and diagnostic acumen. His role was a catalyzing-educative one. There was, then, an hour group meeting for each 70-minute contact meeting with the child which appears to have provided a very useful vehicle for relaxed exploration and consolidation of experience.

Perhaps a concrete resume of the principal theme of a single discussion meeting can serve to illustrate the nature and purposes of these meetings more effectively. One of the undergraduate volunteers began the meeting by reporting what she described as a "puzzling and perplexing" experience she had just had. At the end of the day's activities with her youngster, she had brought him to his home, which was very close to the school. His mother greeted her, seemingly in a friendly way, yet the volunteer remained perplexed by the encounter. As the leader and group members inquired further about her puzzlement, the story unfolded in greater detail. Though the mother had indeed been friendly and smiling, she had, first, completely forgotten the volunteer's name. She was "most apologetic" about this but assured the volunteer that she knew exactly who she was—i.e., "the teenager who baby-sits with Jimmy after school." The conversation between mother and volunteer continued in the presence of the child. The latter was trying to show off his pet guinea pig but was, throughout, successfully ignored by his mother. Several further aspects of the ensuing conversation between mother and volunteer each contained the same unrecognized contradiction, namely that although the mother's external manner and facade was quite pleasant and friendly, the underlying communication was always cutting, biting, and hostile. Gradually the group as a whole was able to reach a crude understanding of this internal inconsistency, and the volunteer was better able to comprehend the basis for her original vague feelings of puzzlement. In essence, the volunteer was experiencing a type of "double-bind" in the communication from the mother. Once grasped, it was possible to explore profitably the potential element of double-binding that might inhere in the mother's day-to-day communication with her son, how this might affect the child, and how it might relate to his present difficulties. Thus, the total discussion period may have contributed in small measure to the volunteer's (as well as to the entire group's) understanding of herself, the adult interaction, the volunteer-child interaction, and the dynamics of the child's present behavior.

The attachments formed between volunteers and youngsters were, in many instances, quite close ones. Volunteers frequently brought games, food, and materials for special activities with the children. Arrangements were also made (in response to the very strong and persistent requests of volunteers) to have additional special activities on either an individual pair or a large-group basis. Thus, many volunteers brought their youngsters up to the campus to see the university, to have dinner with them, to watch a ball game, etc. Trips to the downtown area, to the humane society animal shelter, and to the zoo were arranged. During vacation periods (for the youngsters or the volunteers) several brief correspondences developed.

Although it is premature to know the specific effects of this program, it is already quite clear that the youngsters enjoyed it very much. Many viewed this contact as a highlight of the school week. At the end of the program volunteers submitted fairly lengthy accounts describing their reactions to the program. It is clear that the experience was, by and large, a very valuable one for almost all the volunteers; one or two described it as one of their most exciting college experiences. The oft-noted tendency of students to contrast the experience favorably with lecture classes in psychology reflects the satisfaction of learning by doing and being concretely involved in a situation of psychological import.

Although the student-volunteer program was set up and field tested for several months primarily with the idea of helping to identify an effective model for longer-range utilization in the future, a concerted attempt was made to undertake at least a crude evaluation of various of its aspects. There was concern not only with the obvious question of what is the effectiveness of this program on its consumers (i.e., the referred, emotionally disturbed, primary-grade school children) but also with a number of related and important issues. Among the latter are included the following questions. What, if any, are the distinguishing attributes of the volunteer for a program of this type? What changes take place in the volunteer's attitudes and orientations as a result of participation in the program? What volunteer attributes, be they attitudinal, personality, demographic, or behavioral, predict to favorable or unfavorable outcomes with children exposed to the program?

In the interest of shedding some partial light on these pertinent issues, a modest amount of data collection was undertaken. To start with, graduate student interviewers did a series of ratings of relevant personality and behavioral dimensions for all volunteers based on the interview contact. In addition, they made overall judgments of how much they liked the volunteer and how effective they estimated he would be in the program. Before the program got underway, each of the 17 volunteers completed a 17-item attitudes-to-children questionnaire (Gildea, Glidewell, & Kantor, 1961) and a series of semantic differential ratings (Osgood, Suci, & Tannenbaum, 1957) based on a variety of scales (primarily evaluative ones) applied to concepts such as children, mental health, schools, emotionally disturbed children, and "myself." Additionally, the graduate student interviewer also made semantic differential ratings of the concept "myself" from the frame of reference of how he judged the volunteer had made these ratings. Thus, a discrepancy between actual self-image and judged self-image was available for each volunteer. It was made quite clear at the very outset that these data were not to be used for selection purposes (which they were not), but rather were part of a research appraisal of the overall program.

A control group of 8 education majors and 9 psychology majors, comparable to the volunteers except for the fact that they did not actually volunteer for the program, was tested on the same set of instruments. This made possible comparison of volunteers and nonvolunteers on the revelant dimensions. At the very end of the program the volunteer group retook the same test battery so that attitude change resulting from participation in the program could be assessed.

Each volunteer submitted, at our request, periodic objective ratings of the child and the nature of their relationship, as well as the process summaries describing their actual allocation of time to the various activity categories. In this way it has been possible to reconstruct a view of the total process and its range of manifestation, as it has evolved. This type of information may contribute to the development of an understanding of the most effective types of contacts, activities, and experiences for achieving certain behavioral objectives. As noted above, each volunteer, at the end of the experience, submitted a prose account of his reactions to the project and his suggestions for modification in the future. These reactions, in addition to reflecting enthusiasm, have been helpful in identifying needed areas of improvement. Perhaps the greatest concern of the volunteers was that contact with the child was for too short a period of time, this accompanied by the preoccupation that beneficial effects might not endure. Our concurrence, as viewers of the total process, with this particular critique led to the extension of the program over a full half-year period during the second year.

A variety of criterion measures are available as a basis for evaluating outcome and for assessing input variables which may make for more or less favorable outcome. In the first place, postexperience ratings of behavior symptoms, overall adjustment, and adjective checklist by the referring source have been collected. These are available for both experimental and control Ss and parallel exactly the comparable pre-experience measures, thereby providing a basis for determining change scores and a crude framework for evaluating program effectiveness and variables which may relate to effectiveness. Since posttest measures by referring agents in the school may be contaminated by awareness of the child's assignment to the experimental or control group, an attempt was made to supplement them by observation of actual classroom behavior by naïve judges trained for this function. To this end an 18-item behavior rating scale has been developed, and reliability has been established on a primary-grade sample drawn from another school. Each experimental and control child has been observed twice for 45-minute periods in his natural classroom setting. Since the observers were totally naïve with respect to knowledge of experimental versus control status of the children, this provides a type of criterion judgment that is entirely independent of the project personnel. From the foregoing cluster of measures, as well as from a series of actual behavioral measures taken primarily from school records (e.g., attendance data, report card data, nurses' referrals), a network of evaluative criteria which provide a reasonably comprehensive and solid base for evaluation is available.

Data analyses based on the first-year group have, by and large, been completed. These analyses are limited primarily by the relatively small size of our child and volunteer samples. However, on the basis of completed analyses, preliminary impressions concerning several guiding research questions are available. Although these data have been written up more extensively in another paper (Cowen, Zax, & Laird, 1966b), it may be appropriate to recapitulate several highlights of the findings to date here. For one thing, it appears that our volunteer group was initially significantly different from their demographically comparable nonvolunteer controls with respect to attitudes. The principal substance of this difference resides in the characteristically over-idealistic initial response of the volunteers. Schools, teachers, principals, mental health, mental health workers and other such "institutional" concepts were all seen by the volunteers in an unswervingly favorable light. In a very substantial way the foregoing findings parallel those reported in an earlier chapter in this volume by Holzberg, Knapp, and Turner for their college student volunteer groups.

Participation in the program apparently affected the attitudes and perceptions of the volunteers so that the idealized halo attached to these institutional concepts wore off. Relevant posttest ratings, though still quite positive, were so to a significantly lesser degree than had been the original ratings. It might be said that the postexperience ratings of "institutional" concepts by volunteers was more "healthily realistic." Nor did this change appear to be a reflection of a global change in response style, since on another concept, emotionally disturbed children, rated initially in a rather neutral-negative way by the volunteers, the postexperience ratings were significantly more favorable. Thus, apparently, exposure to and interaction with these youngsters became the basis for more positive and accepting attitudes toward them.

Finally, there is some evidence suggesting that certain types of actual volunteer-child interactions (e.g., amount of time spent in talking and conversation), as reflected in our on-going process description measure, appear to relate to pre-post behavioral change scores in the youngsters. This type of datum may ultimately contribute to a better understanding of the nature of helpful, as opposed to inert, interactions and interventions.

It should, however, be reemphasized that this program was set up primarily to determine, clinically, whether or not it was a workable one. The impression of those involved in the program is that it makes good sense, that it works well, and that children, parents, teachers, school personnel, and volunteers all seem to think very highly of it. Symptomatic of this judgment is the fact that the volunteering per cent by invited parents for their children was 100 and that the consistent feedback from the sources mentioned above was positive and highly reinforcing during the program period. Considerable anecdotal evidence supports this judgment. In several instances, for example, youngsters who became ill in school on a program day were unwilling to be sent home because they did not wish to miss out on this highly valued experience. In another case, a youngster with a greater than 50% absenteeism history did not miss a single program day session. On the other hand, however, the entire first-year program period on which the most evaluative data is currently available was extremely brief, broken by two vacation periods, fundamentally exploratory in nature, and targeted to a very small group of subjects (N=17). Hence it would be unduly optimistic to expect sweeping change on our criterion measures. This is especially true because the control group is a particularly severe one, by virtue of the fact that its members were also exposed to the everyday experience and impact of the TA program in the classroom—a program which, although manifested in a very different form, had at its core similar aims and objectives. For this reason, it is prudent to view the research venture again primarily in terms of the development of appropriate instruments and techniques and the establishment of workable evaluative models, rather than in terms of grandiose expectations about dramatic substantive change.

OVERVIEW

Perhaps a few final summary comments are now in order. The future course of the program will be guided by actual experience with the several experimental programs described. The future plan is to modify and shore up aspects of program developed up to this point and gradually to introduce new elements into our *overall effort*, depending on specific problems that arise and new needs that are identified. Continued efforts will be made to make it both more effective and more compatible with the concrete school situation. In this regard, it is clear that more group meetings with teachers are indicated and that treatment of teacher and aide as a unit is a more effective way of operating than had been apparent to us in our earlier thinking. The latter is but one symptom of what has, to us, been an incomplete and unsatisfactory attempt to work through fully the complex problem of definition of role-relationships with teachers and aides. At this time, it appears that a combined role for the TA of classroom participant and consultant has proved to be more effective than the full-time participant role.

Conspicuously absent from our new programs thus far has been ongoing contact with parents beyond that reflected by the involvement of first-grade mothers in the social work interview. It has been hoped that as a result of their introduction to and contact with a school mental health worker early in their child's school career parents might more willingly turn to school mental health personnel in times of future need. Although there is quite likely merit to this viewpoint, it should be possible to do more to encourage parents to use such services and to view the school as an interested and helping organism, long before they are forced to because of psychological crisis and emotional emergencies.

An initial venture in this direction was undertaken in a limited way during the late stages of the second project year. A group of 25 mothers of primary-grade children classifiable as underachievers was invited to attend a series of four morning meetings at the school dealing with the general issue of how parents can be helpful in promoting their children's achievement in school. Seventeen of those invited expressed interest. Of these, 7 worked and were therefore unable to attend at the scheduled time. Of the remaining 10, 8 have regularly attended the meetings, conducted jointly by the project psychologist, the social worker, and the consulting psychiatrist. The discussions have ranged across topics such as sex instruction, discipline, and authority and have been active and ego involved in terms of feeling tone. Evidence of the mothers' tendencies to overprotect their children has been strong. Much of the discussion has taken place among the mothers themselves, and the professionals involved have attempted to keep the focus on the child and his problems rather than encouraging the mothers to introduce or to emphasize their personal problems.

There has been a calculated decision to confine the parents' meeting, for the initial run, to a group with a relatively homogeneous focus (i.e., their underachieving children), but not because this is the only parent group to work with or the most important one. Rather it provides a paradigmatic and relatively focused situation in which a model can be worked out which subsequently may be broadened so as to include other parent groups. Certainly, future efforts will increasingly be devoted to the development of this phase of the program.

It is to be emphasized that the foregoing is a description of a set of programs which is barely off the drawing board. They are types of programs which make very good sense to the authors on logical and intuitive grounds. Their salient features include: emphasis on the very young, focus on early detection and early secondary prevention in an effort to forestall later full-blown development of serious and frequently immutable pathology, recasting of the roles of professional specialists in a way which may have potential for reaching much larger segments of our population currently requiring help, utilization of subprofessional manpower with focal time-limited training as a paradigm for a needed type of geometric expansion of our helping structures.

All of this seems to make perfectly good sense in view of the growing body of knowledge about professional manpower shortages, the ineffectiveness of traditional techniques with large segments of our population, and the fact that mental health needs far outstrip available resources (disproportionately so as a function of geographic, educational, economic, ethnic, and socioeconomic factors). But, in the last analysis, it is clear that this is logic rather than empirics. The social situation in the mental health area is sufficiently acute to demand vigorous exploration of new helping approaches. On this basis, it is felt that programs such as the foregoing are more than warranted. However, one should not lose sight of the fact that basic recasting of the models of the helping professions must await the painfully slow accretion of solid empirical data.

REFERENCES

Cowen, E. L., Izzo, L. D., Miles, H. C., Telschow, E. F., Trost, M. A., & Zax, M. A preventive mental health program in the school setting: Description and evaluation. *J. gen. Psychol.*, 1963, *56*, 307-356.

Cowen, E. L., Zax, M., Izzo, L. D., & Trost, M. A. The prevention of emotional disorders in the school setting: A further investigation. *J. consult. Psychol.*, 1966, *30*, 381-387 (a)

Cowen, E. L., Zax, M., & Laird, J. D. A college student volunteer program in the elementary school setting. *Comm. Ment. Health J.*, 1966, 2, 319-328. (b)

Gildea, M. C.-L., Glidewell, J. C., & Kantor, M. B. Maternal attitudes and general adjustment in school children. In J. C. Glidewell (Ed.), *Parental attitudes and child behavior.* Springfield, Ill.: Charles C Thomas, 1961. Pp. 42-89.

Osgood, C. E., Suci, G. J., & Tannenbaum, P. H. *The measurement of meaning.* Urbana, Ill.: University of Illinois Press, 1957.

19

PROJECT RE-ED: EDUCATIONAL INTERVENTION IN DISCORDANT CHILD REARING SYSTEMS

W. W. Lewis

George Peabody College for Teachers

Project Re-ED is a combined demonstration, training, and research endeavor sponsored by George Peabody College for Teachers and the State Departments of Mental Health in Tennessee and North Carolina. Reduced to simplest terms, the objective of the project is to test the feasibility of a brief, high impact residential treatment program for emotionally disturbed children, reinforced by mobilization of resources in children's "natural" environments. Each of the two states maintains a small residential school, with financial assistance from the federal government.[1] Peabody College provides a training program for staff of the two schools, a research program to evaluate the effectiveness of the schools, and general coordination of the total project.

Conventional treatment programs for emotional disturbance in children reflect what Thomas Szasz (1961) and others have referred to as the "medical model" of behavior disorders. Briefly, the central assumption behind the medical model and much of our elaborate network of treatment facilities for children is that emotional disturbance reflects an underlying pathology within a child which, if not corrected, will develop into more serious behavioral manifestations during adolescense or adulthood. In the early part of the century, as the mental hygiene movement was beginning, disordered behavior could often accurately be attributed to an underlying physical disease process such as general paresis. The mental hygiene movement embraced the assumption of a disease process and extended it, by analogy, to the total range of behavior disorders. Adolph Meyer was most articulate and influential in developing our basic pattern of secondary prevention of mental illness through child guidance clinics. Contemporary patterns of treatment of emotional disturbance continue to reflect his conception of a broader disease process and his conviction that many of the "mental tangles" of adult patients could have been prevented by treatment when the problem was first manifest during childhood (Kanner, 1962).

---

[1] The program to be described has been supported by an NIMH grant, MH 929.

There are two sound reasons for experimenting with alternative modes of treatment for behavior disorders in children. The first, obviously, is shortage of mental health manpower. George Albee (1959) put it most concisely in his summary of nationwide mental health manpower needs. "We must conclude this survey with the prediction that our country will continue to be faced with serious personnel shortages in all fields related to mental illness and mental health for many years to come. Barring the possibility of a massive national effort in all areas of education, with all of the social changes such an effort would imply, or the possibility of a sharp breakthrough in mental health research, the prospects are pessimistic for significant improvements in the quantity or quality of professional services in these fields" (p. 259).

The second reason is the current questioning of the efficacy of methods traditionally used in secondary prevention. Studies of the effectiveness of psychotherapy with children can be summarized rather briefly by saying that two-thirds to three-fourths of the treated cases show durable improvement regardless of the type of treatment setting, the professional training of the therapist, or the age of the children treated. While this would seem to be a favorable commentary on the general effectiveness of clinical treatment, studies of children on clinic waiting lists who have not received psychotherapy also report improvement rates in the two-thirds to three-fourths range (Lewis, 1965). A number of questions may be raised about the appropriateness of waiting list defectors as controls in outcome studies. However, the important point is not that psychotherapy is ineffective, but that there is reasonable doubt, since effectiveness has not been clearly demonstrated in the research that is available. These two issues compel some experimentation with alternative patterns of treatment based on different concepts regarding discordant behavior in children.

Project Re-ED is one such experiment. It was initiated in September, 1961, with a nine-month training program at Peabody College for thirteen carefully selected elementary school teachers. The teachers were selected on the basis of unusual teaching competence, as judged by their supervisors and colleagues, adaptability and creativity in the teaching techniques they used, and a genuine interest in the education of emotionally disturbed children. The training program for the first group of teachers, later called teacher-counselors, consisted of two academic quarters of course work at the graduate level followed by a three-month internship in an established residential school for emotionally disturbed children, including some placements in England and Scotland.

During the school year of 1962-1963, Cumberland House Elementary School in Tennessee and Wright School in North Carolina began to operate on a limited basis, staffed by the group of teachers who had gone through the first year's training program. The training program at Peabody has continued to supplement the staff of both schools as vacancies have occurred and as the program has expanded. Each school is organized into groups of eight children, who live and attend school together and who are the responsibility of two teacher-counselors. The average length of enrollment is six to seven months. The general pattern that has been followed in both schools is a five-day-a-week residential program, with children returning to their own homes on the weekends. The two teacher-counselors are responsible for designing and carrying out an intensive treatment program for each child, based on his needs, presenting problems, and the common objectives shared by the child's family, the referring mental health agency, and the Re-ED school.

The initial thrust of the demonstration was directed toward a total educational milieu for a troubled child. Traditional residential treatment centers provide a few hours each week with highly skilled, and highly paid, professional personnel, but also long periods of inactivity and idleness, supervised by staff of marginal competence. They also tend to isolate the child from his natural environment—family, school, and friends—to which he must eventually return. The Re-ED staffing pattern is intended to address itself to both these problems. It seeks, first, to provide an engaging, goal-oriented educational climate during all of a child's waking hours and, second, to keep him related to his own child rearing systems by weekends at home and by careful liaison work that prepares the way for his return after a brief stay at the Re-ED school.

An Overview of the Program

The Re-ED schools emphasize the educational quality of their program in designation of roles—teacher, student, principal; in designation of activities—enrollment, recess, student council; and in designation of limited goals which lend themselves to direct teaching. The language of mental hospitals and clinics is intentionally avoided. This does not represent a denial of shared responsibility with the mental health professions. It represents, rather, an assessment of the potency of teachers and educational processes in the socialization of children, "disturbed" as well as "normal." While the staff of the schools are as comfortable in dealing with an outburst of negative feeling as with a problem in remedial reading, they prefer to define their role as educational rather than therapeutic.

The reason for making this distinction is the emphasis in the Re-ED program on short-term, specific, and usually rather concrete goals toward which the individual child and his teacher-counselors work. There is none of the emphasis on psychotherapeutic treatment for intrapsychic problems that characterizes many programs. Most treatment programs are based on the notion that an uncovering of hidden psychic processes will lead indirectly to significant behavior change. In treating a child with a reading block due to emotional factors, for example, both the child and his parents are required to work through the feelings they have about each other in psychotherapy. The expectation is that once the participants have achieved an understanding of the emotional factors in the problem, the reading block or other presenting symptoms will dissipate. With deep-seated problems, this approach to emotional disturbance may be necessary; but it is a long and expensive route and may not be required with less complex behavior problems also grouped under the general heading of emotional disturbance. The Re-ED demonstration is exploring the extent to which direct educational programming can be effective in modifying relationships between children identified as emotionally disturbed and their socializing systems.

The Re-ED treatment pattern assumes a basic validity in the traditional child-rearing arrangements in our culture, that they are, on the whole, effective and wholesome for a child's development. A disruption of child-rearing functions, as manifest in the identification of a child as emotionally disturbed, is therefore looked upon as a disturbance within the systems influencing that child, rather than within the child himself. If the disruption in the child-rearing systems for a child is not completely enervating, the relief provided by a fairly rapid shift in symptoms, or in demands on the child, may allow the systems to recover their potential for growth and continue the socialization process relatively unaided. With this hypothesis in mind, goals are set for children at the Re-ED schools emphasizing things like reading skills, learning to tolerate sitting in a classroom for extended periods of time, trusting adults, and living with peers with a minimum of conflict. In many ways, this approach to a child's problems may be thought of as social, rather than psychiatric, treatment. The Re-ED strategy is to look at the effects of the child's behavior at an overt, symptomatic level and to see in what specific ways his behavior creates conflicts with the social systems of which he is a member. Then an attempt is made to construct a sequence of learning experiences that will influence, quite directly, the area of concern in the child's behavior.

The process begins with a referring agency—child guidance clinic, family service agency, school, or other community agency involved in the identification or treatment of emotional disturbance in children. The Re-ED school is not seen as a sufficient or autonomous treatment facility, but as a resource for agencies in the community already working with children. In most cases the agency referring a child to a Re-ED school will continue to work with the parents while the child is enrolled in the school. The admission conference, between the referring agency and the Re-ED school, reviews the history of the child's problem, any treatment of the problem attempted to date, and the current status of the child, his family, and school. Preliminary treatment goals are established at the admission conference, with an emphasis on specific changes that can be made rather quickly in the child's behavior, or in his natural environment, within the realistic limits imposed by the intent to return him home quickly. Planning for the child's release, including additional community resources that need to be mobilized, is initiated at the admission conference and is an integral part of the treatment pattern. These plans remain flexible to allow for the unpredictable in human and institutional behavior, and the thrust is forward, anticipating future behavior rather than explaining past events.

There has been a gradually diminishing concern with the kind and degree of pathology in making the decision to enroll a particular child. When the schools were first opened, rigorous use was made of exclusion criteria like severe psychosis, brain injury, and mental retardation. As the confidence and skill of the staff have grown, the admission decisions have come to reflect a judgment that a child and his socializing systems can respond in specified ways to the group-centered educational program and mobilization of community resources. This attitude has resulted, of course, in the admission of children with a wide range of diagnostic labels, although each child must have some unique strengths that can be exploited.

By and large, children admitted to the Re-ED program range in age from six to twelve years. The modal age is ten, and perhaps two-thirds to three-fourths of the youngsters in residence at any given time are between the ages of ten and twelve. Of the thirty-two youngsters accommodated by the program twenty-four are boys and eight are girls. Although this is largely a matter of administrative and housing convenience, the numbers reflect quite faithfully the ratio of referral of boys to girls by community agencies and clinics.

Following the admission conference, the child is assigned to a particular group; and the specific preparation for his enrollment begins. He visits the school, with his parents, and meets the children and teacher-counselors with whom he will be living for the next few months. The teacher-counselors begin to outline a specific program of remedial education and social living experiences, based on their analysis of the details in the clinical and education records on the child. In addition, they prepare the other children in the group for the coming of the new child, so that on the day of his enrollment he will be received warmly, on the basis of realistic expectations, including whatever problem behavior he is likely to present to the group.

The school day typically begins about 9:00, proceeds until noon, with time out for a recess period, and resumes after lunch until about 3:00, when the recreation period begins. The school day is heavily loaded with instruction in basic academic skills: reading, arithmetic, and use of language. Since the placement of children in groups is based more on social behavior than educational development, much of the instruction in basic skills is individualized; and the content is determined by the social utility of a skill for a particular child. However, units of instruction that will support heterogeneous educational abilities, such as preparing for a field trip to the Smoky Mountains National Park, are also a vital part of the school curriculum.

The nonacademic part of the school day also emphasizes the learning of skills which have social currency for elementary school age children, but which, for some reason, have not been developed. The ability to kick a football, for example, or to roller skate, swim, or ride a bicycle may have a social utility as great as arithmetic skills in a child's reintegration into his normal school and home environment. Thus, a program of planned instruction, reflecting an assessment of a child's need for socially adaptive skills, is extended beyond the bounds of the usual school day. This is true also of the evening program, which emphasizes the skills required in living harmoniously with a group of peers and the adults to whom a child is responsible. It is one of the important strengths of the Re-ED staffing pattern that the afternoon and evening hours, including the homely child-care tasks of eating, dressing, and getting ready for bed, are supervised by sensitive, competent personnel. While much of the interaction of this time is not planned in any specific sense, it is a time that is rich in opportunities for learning skills in social living and exploration of personal feelings. The way an adult responds to a child's refusal to eat or to go to bed, or his strong impulse to hurt another child, can make an important contribution to the child's social and emotional development. The intensity and intimacy of group living provide opportunity for personal growth that is not encountered elsewhere.

Each child's progress toward his goals is reviewed periodically, along with the progress being made in planning with the child's family, school, and community resources. As soon as a judgment can be made that the child is functioning just well enough, and/or the systems in his community are changing their tolerance thresholds enough to support his behavior without undue conflict, and with a reasonable prognosis for his continued healthy development, plans will be made to return him to his own home and school. During this time the teacher-counselors become more active in working with the child's parents and regular teacher. The Re-ED staff, the referring agency, the child's family, his school, and the child himself are all actively involved in planning the return.

SELECTION AND TRAINING OF STAFF

One of the innovations in Project Re-ED is the development of a new professional role identity, the teacher-counselor. The teacher-counselor is an educator whose role definition has been radically expanded from that of the classroom teacher. He is, of course, first a classroom teacher with skills in teaching basic tool subjects to elementary age children. He is also a counselor, recreation supervisor, camper, parent surrogate, and general handy man. In addition to the multiple skills required for working effectively with children in a total educational milieu, he must be conversant with the language of the mental health specialists who refer children to the school and to whom he turns for consultation.

The teacher-counselor role is an attempt to provide one model that may ease the acute shortage of highly specialized mental health professionals. Basically, the idea is to recruit successful, young public school teachers, provide them with a brief but rigorous training program, and give them support from mental health professionals as they move into positions of responsibility on the staffs of the Re-ED schools. This plan of induction into a professional role has several advantages over the training in the traditional mental health professions. The first, obviously, is time. Less than one year of graduate study is required. The shorter time in training is possible because the teachers selected for the program have already demonstrated competence and developed a repertory of skills with children in a public school classroom. The second advantage is that the experience these teachers have had in regular classrooms allows a realistic estimate of their future performance, based on supervisors' and colleagues' evaluations. It is an attempt to take advantage of the natural variation of behavior among teachers and to bring into a training program persons with demonstrated empathy with children's problems, creativity in approaching human relationships, and so on, rather than depending on the development of these necessary characteristics in a training program. A third advantage is in the efficient utilization of mental health professionals in training and consultation. The year of formal training only launches the teacher-counselor on a course of experiences which brings him much later to mature, well-rounded professional competence in planning a total educational program for disturbed children. A key ingredient in these experiences is the availability of frequent consultation with psychologists, psychiatrists, and social workers.

The training for teacher-counselors consists of three academic quarters of course work and practicum that lead to a master of arts degree in special education, with emphasis in the area of emotional disturbance. The program of study presumes an acquaintance with educational procedures for normal children and builds upon this background. Course work introduces trainees to concepts and procedures used by the mental health professions in working with emotionally disturbed children, educational procedures currently being used in school programs for emotionally disturbed children, and milieu treatment techniques used in residential settings. In addition to the courses that are aimed specifically at work with emotionally disturbed children, trainees take courses in remedial reading, clinical-educational diagnosis of learning difficulties, and techniques of counseling.

Each trainee is also engaged in a practicum throughout the three academic quarters. The practicum emphasizes three kinds of experiences: (1) clinical education with individual children, (2) small group teaching, and (3) liaison work with families, schools, and community agencies.

The practicum is centered in the program at Cumberland House, the Re-ED demonstration school in Nashville. Each trainee has opportunity for observation and increasingly responsible participation in all parts of the program. While the work of the school does not depend upon teacher-counselors in the training program, all assignments are intended to provide a real service as well as an opportunity for the trainee to learn more effective techniques of educational planning for disturbed children. The assignments vary with the needs of the trainee, but may include tutoring a child who is nearing the end of his stay; developing a remedial reading program for a nonreader; providing an enrichment program for a group of children in music, art, and science, etc.; or working as an assistant to a teacher-counselor or liaison teacher.

THE STAFFING PATTERN

There are four roles which, in combination, provide the unique operational pattern in a Project Re-ED school as it attempts to influence not only the behavior of a child but the primary socializing systems to which the child will return. These roles are (1) teacher-counselor, (2) social worker, (3) liaison teacher, and (4) consultant.

THE TEACHER-COUNSELOR ROLE

It will already be quite clear that the success of a Re-ED school is highly correlated with the success of individual teacher-counselors in planning and carrying on effective programs for children. Two teacher-counselors work as a team with a group of eight children, setting goals, planning daily programs, evaluating progress, and articulating their efforts with the plans for parents, home schools, and community agencies. In consonance with the objective of helping smooth the child's return to his home, school, and community, the teacher-counselor's initial goal-setting reflects a kind of "social systems" diagnostic thinking. Specific behaviors that have in the past created discordance are likely to be reflected in the goals set for a child. Since most of the children referred have a history of academic difficulties, goals involving school achievement are likely to be given prominence and can be formulated quite specifically. Problems related to social responses or emotional reactivity are likely to be stated in general terms at the time a child is admitted to the school and sometimes may require a period of observation by the teacher-counselors before particular goals can be formulated. There is a continuous application of two criteria: (1) goals must be responsive to the social milieu to which the child will return and (2) goals must be feasible in a program of brief educational treatment.

The program planned for a group of children by the two teacher-counselors also reflects two kinds of concerns, the individual goals just mentioned and group process goals. The work toward individual goals takes place largely in the context of group interaction. Most children referred for residential treatment need to learn new techniques for relating to peers and to important adults in their lives. Planning for an overnight camping trip, a car-wash to earn extra money, or the building of a tree house provides a task orientation around which conflicts occur and problem-solving processes evolve. The teacher-counselors engage in a constant cycle of planning, carrying out of plans, and evaluation of results in giving direction to the group process and the achievement of goals for individual children.

Two slightly different roles have emerged for the two teacher-counselors working with a group of children. Although both come from an educational background and have received similar training, one works with the group during the day, primarily in the classroom, and emphasizes the formal teaching aspects of the role. The other works with the group after school and during the evening and emphasizes the informal counseling, group work aspects of the role. They meet each day for one to two hours to review goals and day-to-day planning in order to maintain maximum consistency in an educational milieu during each child's waking hours.

THE SOCIAL WORKER ROLE

The only representative of the traditional mental health disciplines in a full-time staff position at a Re-ED school is the social worker. It is a somewhat unusual social work role, eschewing direct service and working as a coordinator of the total program for a child enrolled in the school. Initially, this involves development of referral information with an agency or clinic and planning with the agency and family for the child's enrollment. The total plan will involve four aspects: (1) the work of the teacher-counselors with the child, (2) the work of the referring agency with the child's parents, (3) the work of the liaison-teacher with the child's regular school, and (4) any special community resources that need to be developed for a particular child, such as remedial tutoring, YMCA membership, a part-time job, etc. The total plan is cast in broad outline before a child is enrolled and is monitored and modified, if necessary, by the social worker. The strategy of working with all the child's socializing "systems" is seen most clearly in this coordination of several different attempts to facilitate the functioning of a child in his various social milieus. Since the general treatment goal encompasses more than change in the child's behavior, a shift in parental attitudes, a move by the family to a new neighborhood, or the availability of a particular classroom placement may hasten the return of the child to his natural environment. It is the social worker's responsibility to be sensitive to these changes as they occur and to articulate the several efforts as they interact in developing a mutually positive relationship between the child and the social system to which he will return.

THE LIAISON-TEACHER

The liaison-teacher role reflects our perception of the importance of school in a child's life. To some extent, the success a child has in coping with problems arising from demands made on him at school influences more global appraisals of him made at home and elsewhere. The liaison-teacher has the same background of experience and training as the teacher-counselor; some are former teacher-counselors. The role revolves around articulation of the public school and Re-ED experiences for a child. Initially, before enrollment in a Re-ED school, the liaison-teacher makes a careful appraisal of the sources of discordance between a child and his school, ranging from specific reading disabilities to mannerisms that annoy his teacher or peers. This appraisal receives careful consideration in setting goals for the child. During the time the child is enrolled in the Re-ED school, the liaison-teacher helps him maintain contact with his home school through conferences with his teacher, approximating assignments wherever possible, exchange of letters with classmates, etc. As the planning for his return gets under way, the liaison-teacher discusses with the home school teacher the remedial techniques that have been used, any special management problems that may still be anticipated, and program modifications, within the realistic limitations of a public school situation, that may be required. Following the child's return, the liaison-teacher helps ease the transition by maintaining regular contact as an educational consultant to the classroom teacher.

THE CONSULTANT ROLE

The mental health specialist in the Re-ED schools functions as a consultant. One of the general aims of the project is to develop more efficient use of the available supply of psychiatrists, psychologists, and social workers. In line with this aim, the Re-ED schools use only educators in direct service roles with children, with mental health specialists in consulting roles.

After experimenting with a variety of consulting patterns, three have emerged as ways of integrating the body of knowledge of the mental health professions into the operational pattern of a residential school. First, consultants are used to help evaluate existing clinical records on a child before he is enrolled. Second, many kinds of specialists are on call to meet with teacher-counselors on unusual problems, not only mental health professionals but specialists in pediatrics, physical education, social group work, elementary education, etc. The third pattern of consultation is the regular program consultant, usually a psychologist, who meets at least once a week with the two teacher-counselors to help evaluate goals and techniques for individual children. The consultant comes to each session with his background of professional skills and specific knowledge of the child being discussed but with no authority to make decisions in program planning. Decisions are made by the two teacher-counselors and are clearly defined as working hypotheses to be tested in the program and continued or discarded on the basis of feedback from a child's behavior. The relatively heavy investment in consulting time is intended not only to provide teacher-counselors with whatever help they need in solving problems of the moment but to provide a learning experience that will allow teacher-counselors to develop into behavior specialists in their own right.

INTERVENTION IN SOCIAL SYSTEMS

The initial impetus for Project Re-ED came from a desire to create a staffing pattern that would substitute for the more expensive traditional patterns of treatment for emotionally disturbed children. In choosing to use educational personnel and techniques we made an implicit choice not to use the psychotherapeutic model, but to evolve our own conceptual framework from experience with the new staffing pattern. We were obliged to limit ourselves to specific goals relevant to a child's natural environment which could be achieved in a short-term program relying on direct teaching and an educational milieu. The more conventional treatment programs do not always aspire to complete "cure" of a child's problems, but they do tend to set ambitious goals with respect to the development of new response patterns. They also tend to accept more or less total responsibility for modification of a child's behavior to allow him to cope with all of the possible stresses he might encounter as he moves back into his natural environment.

The emphasis on specific, short-term goals in the Re-ED schools has led to a different way of thinking about emotional disturbance. One begins with the premise that the identification of a child as "emotionally disturbed" reflects a state of discordance between a child and the primary agents of his socialization, rather than a psychological condition within the child. It is a judgment that the normal process of socialization has been interrupted.

The socialization of a child proceeds through the mediation of a set of small social systems, primarily his family and his school, with support from informal and formal peer group units such as boy scouts, church groups, and so on. One may think of a family or a school classroom as a miniature, relatively self-contained social microcosm with a system of values regarding mutual expectations of the participants toward each other. In a family unit the parents, as the socially-sanctioned transmitters of the culture, value certain behaviors, attitudes, and feelings in their children as evidence that the system is maintaining satisfactory progress toward one of its goals—developing a fully socialized adult. A child's responsibility in the socialization process is to learn the valued attitudes and behaviors of his socializing systems. Most children do. Those who do not, or who do not seem to be making reasonable progress toward the desired behaviors, may be identified as emotionally disturbed. Operationally, this takes place when a parent's assessment of the discrepancy between expectations and behavior is so great that home remedies are no longer sufficient and assistance is required from professional child-socializing agencies in the community.

This mode of thinking leads to reconceptualization of objectives. Instead of concentrating, as therapeutic programs do, on the intrapsychic life of the child and aspiring to a fundamental reorganization of personality, one concentrates on the needs of the social systems of which the child is an integral part; the goal becomes one of making quite specific changes to facilitate the functioning of the child's socializing systems. The achievement of this goal might be furthered by a number of interacting events: by changes in the behavior of the child, by greater family stability, by changes in the program of the child's own school, by providing the family and child access to a community center, and so on. All components might improve a little or one component might improve a lot; either development could get the systems above threshold for sustaining the child and make them "go."

While the child and his pattern of behavior are important in the planning of treatment, he is not the sole focus of concern. One thinks of the entire complex of socializing systems that influence the child as the locus of discordance and the field into which one introduces change. The concept is similar in some ways to what Barker and Wright (1955) have called psychological ecology. Their interest, however, is in the influence of behavior settings on individual behavior, while ours is in the location of points of discordance between a particular child and all of the behavior settings that make up a set of socializing systems for him. This means that the specific behavior settings with which we are concerned will change from child to child, but will include his home, his school, and the formal or informal peer group activities in which he is currently engaged. The particular constellation of systems for a child who is identified as emotionally disturbed is seen as temporarily out of balance. The specification of the discordance, in turn, leads to the specification of objectives—with regard to the child's behavior, parents' expectations, school programs, additional resources in the community, etc.—that would be expected to facilitate the functioning of the entire system.

How shall we talk about the content of discordance and the planning of programs to reduce it? We are still groping toward an internally consistent language that will give substance to the bare ribs of our umbrella concept of discordance in child-socializing systems. Neither the vocabulary of education, emphasizing cognitive aspects of normal child development, nor the vocabulary of mental health, emphasizing idiosyncratic emotional development, offers the perspective we are seeking. One possibility is role theory concepts, liberally reinterpreted to fit our need to talk about relationships within a complex of social systems (Brim, 1959).

Role theory concepts are based on an interaction of two persons with complementary expectations. Whatever the nature of the two roles—parent-child, teacher-pupil, etc.—the identification of a role-relationship implies a set of mutual expectations that structure for each participant his obligations and privileges with respect to the partner. Most parents, for example, include in their concept of parent-child roles an expectation that the parent provides food, clothing, and protection against physical hazards and that the child conforms to household routines like mealtime, bedtime, and care of family property. The child in the relationship may or may not share the parent's role expectations, but he will have a role concept of some kind. "That's not fair!" or some variant reflects the child's perception of another person's violation of his expectation. The "presenting symptoms" attributed to an emotionally disturbed child may be construed as a judgment by his parents that the child's role performance is not meeting the parents' expectations.

The concepts of *role prescription* and *role performance* are used to distinguish between a generalized social norm and the behavior displayed by a person in the role. A slight modification must be made in analyzing the role-relationship between two particular persons to make the concept of role prescription flexible, depending on the context in which the relationship exists. That is, the child's role prescription for the father-son interaction differs from that for the older brother-younger sister, but the father-son role prescription also changes with the setting—for example, it is different at the supper table than it is at the swimming pool. A child's role prescriptions also change through time as a function of generalized expectations of children of different ages—"He should be able to keep dry at night." "He should be out playing with other boys his age," or "He should be getting interested in girls." They change, less predictably, according to parents' moods or momentary concerns, and thus there is an implicit requirement of children to be sensitive to the current arrangement of values in the hierarchy of role prescriptions held for them by the natural evaluators in their lives.

As psychological constructs for thinking about problems of emotionally disturbed children, role prescription and role performance focus our attention on the visible aspects and judgmental consequences of disturbing or discordant behaviors. Rather than inquiring into the cause of the problem at the level of the psychodynamics of the child, we approach the manifestations of the problem quite directly from the parents' statement of presenting symptoms, or the statements of other "natural evaluators." Reeducation, from the child's point of view, involves the learning of new roles and the unlearning of old roles. For other participants in the child's socializing systems, reeducation may also involve the learning of new roles, but particularly will involve learning of new role prescriptions held for the child. Our efforts in reeducation are therefore directed toward two complementary goals: (1) increasing the congruence between the role prescriptions held by the systems and those held by the child and (2) increasing the congruence between these role prescriptions and the child's role performances. It is the achievement of these goals that reinstates a balance of mutual positive reinforcement and reduces discordance in a system.

What is the content of these role prescriptions and role performances? What is it that a parent has in mind when he thinks about how his child should be? Clearly, one aspect is observable behavior manifested by the child. "He ought to pick up his clothes" or "He ought to read better," for example. In other ways the content of role prescriptions is related to inferred aspects of behavior, a child's motivation or feelings. "He should try harder in school," "He should love his parents," etc. A third element in the content of role prescriptions has to do with the effect of the child's role performance on other persons. "He should be popular with other children" or "His parents should be able to trust him."

Whatever the content of the role prescriptions held for a particular child, his task is to learn the role prescriptions, and their accompanying role behaviors, as they apply to the social interactions in which he participates. He learns that certain ways of thinking and feeling are better than others, that certain ways of behaving are better than others, and that certain reactions from other people are better than others. But he must also learn that "better" varies with which particular person is the role partner and under what particular circumstances the interaction takes place.

In this context, emotional disturbance might be defined as an accumulation of discrepancies between role performances and role prescriptions held for the child by a child-socializing system, such that he can no longer be tolerated by the system in its present state. By this definition, there are two sources contributing to the discrepancy: the child's behavior, broadly construed to include motivation and the social consequences of his behavior; and the parent's expectations, implicit or unconscious as well as explicit, and relative to the vagaries of time and place.

It may be helpful to analyze this discrepancy from the point of view of a child whose role performance is inadequate. Three conditions may prevent role performance that can be evaluated as successful and may lead to a judgment of discordance. First, the child simply may not have the ability to perform the role prescription held for him. Second, he may not be aware of, or comprehend fully, what the role prescription is. Third, he may find the consequences of the role performance less satisfying than those of competing roles. Let us examine each of these limiting conditions.

With regard to ability, our understanding of individual differences requires that we establish realistic limits for our expectations of a child. If an inability involves reading, our expectations of reducing the discrepancy by working with the child would be structured by our understanding of the limitations of the child to learn. Assuming for the moment that most of the discordant behavior we encounter is not a function of mental or physical handicaps, some problems can be classified as simple deficits in specific role performance ability. These involve mostly technical skills and can be dealt with by straightforward remedial programming. The child knows clearly what is expected of him, is motivated to acquire the skill, and is guided through a sequence of experiences that improve his performance, as in a remedial reading or physical education program. While children whose presenting symptoms are as simple as this are not often referred for treatment, most of the children we encounter have ability deficits which do need attention during the later stages of their treatment. There have been other, more pervasive, role behaviors that have interfered with the learning of these specific skills. A boy, for example, who has been unable to formulate for himself a role prescription as an active, assertive male will need considerable practice in athletic games, fighting, or whatever skills are appropriate as he begins to develop his new role.

The second source of discrepancy, the failure of a child to understand what his valued role prescriptions are, presents a more serious kind of problem and will account for many children referred for treatment. Lack of clarity in a child's knowledge of the valued role prescriptions held for him may be based on incomplete or inaccurate information. A boy in a fatherless family may not be able to display role performance congruent with his mother's unverbalized masculine role prescriptions for him simply because he has had no models, human or verbal, available to him. Children's understanding of role prescriptions for them may also be unclear because of conflicting information from different sources, like father and mother or family and neighborhood, or from the same source, which shifts unpredictably between conflicting role prescriptions.

Whatever the source, when a child's inadequate role performance is based on inadequate formulation of his role prescriptions, the program of reeducation must include behavior models in the form of stable adults and verbal analogies. Having children live and work in the company of adequate, responsive adults allows the children to use them as role models. The same general notion is present in the examination of the lives and motivation of great men in history. The more specific aspects of a child's formulation of his own role prescriptions come about in the intimacy of group living, and the conflicts stimulated by this intimacy, with the opportunity for discussion and resolution of varied role performances. Assuming a continuous and realistic evaluation of the role performances that occur naturally in group interaction, new role prescriptions are developed, tested, and clarified, and emerge as new role performances.

In problems that involve failure in role performance due to ability and in problems attributable to a lack of clarity in the child's role prescriptions, one assumes a generally favorable orientation toward other human beings as a source of motivation for new learning. A withdrawn child can entertain and try out new roles if he regards the adults in his new surroundings as generally rewarding. The same will be true of a child who has some sort of serious gap in his repertory of role prescriptions due to absence of experience in some areas of behavior. He will be willing to engage in new role performances if the support and encouragement of adults is gratifying to him. The most difficult problem encountered in the reeducation of disturbed children is one in which we cannot assume the efficacy of social reinforcement. Where a child's inability in role performance can be attributed to unconcern with, or outright rejection of, other human beings as a source of reinforcement, the quality of the problem and the relearning required to cope with it seem very different.

We encounter children who are unresponsive to appeals to try new role behaviors based on acceptance and approval. Their engagements with living are solitary or, where other people do become involved, antisocial and disruptive. It may be useful to think of this kind of problem as primarily motivational and prior in time to the learning of new role prescriptions and role performances in the sequence of reeducation experiences. The two other kinds of relearning depend heavily upon relationships with other persons as a source of motivation. With motivational problems it is the ability to relate that must be relearned—the experiencing of other human beings as dependable sources of gratification. One promising approach to this problem has evolved from an operant learning paradigm, making use of whatever tangible rewards the child is presently motivated toward. A behavior modification program in our setting has a dual function: first, to help the child learn some simple skill, such as conforming to basic classroom routines; and second, to help him learn that there is predictability and gratification in relationships with adults. Simple desensitization routines have also proved useful with children who have school avoidance problems.

Another possibility for a child whose failure in role performance is due primarily to motivation is the development of a separate "vestibule" program before being enrolled in the regular Re-ED school. The readiness of these children for learning academic skills and for discussion of mutual role performances is probably no greater than that of developmentally normal children who are some two or three years younger. Perhaps it is less because of the range of negative responses already learned with respect to other persons. The kind of unstructured, primitive camping program we operate at one of the Re-ED schools may be uniquely appropriate with children whose learning objective is an attitude of basic trust and enjoyment in a relationship with another person. Without the conflicts and antagonisms aroused by schedules and group management problems, a few of these children in the presence of a protecting, nurturing adult can begin to attach a positive valence to the adult which generalizes to other phases of the program. Only after people become rewarding can a child engage himself in the learning of new role prescriptions and role performances.

While it is convenient to separate these three sources of deficit in role performance for purposes of discussion, it is probably not realistic to think of a single child as deficient in ability *or* understanding *or* motivation. Probably most children referred as emotionally disturbed will have a mixture of all three kinds of difficulties contributing to discordance in their socializing systems. The usefulness of the role learning concepts is that they emphasize specific behavior modification in a program for a child and guide our aspirations for, and our evaluation of, his progress. At the same time they identify contributions of the socializing systems to the perceived discordance and suggest modifications in the child's ecology which will support the changes in his behavior. A different parental response to the child's aggressive behavior, a different teacher, enrollment in a community recreation program, and other modifications in the child's natural environment are equally important in a plan to reestablish equilibrium in the total child-socializing system.

REFERENCES

Albee, G. W. *Mental health manpower trends.* New York: Basic Books, 1959.

Barker, R. G., & Wright, H. F. *Midwest and its children.* New York: Harper & Row, 1955.

Brim, O. G. Personality development as role learning. In I. Iscoe & H. W. Stevenson (Eds.), *Personality development in children.* Austin, Texas: University of Texas Press, 1959. Pp. 127-159.

Kanner, L. Emotionally disturbed children: A historical review. *Child Develpm.,* 1962, 33, 101-102.

Lewis, W. W. Continuity and intervention in emotional disturbance: A review. *Except. Children,* 1965, *31,* 465-475.

Szasz, T. *The myth of mental illness.* New York: Hoeber-Harper, 1961.

20

A SCHOOL DISTRICT PROGRAM FOR SCHIZOPHRENIC, ORGANIC, AND SERIOUSLY DISTURBED CHILDREN

George T. Donahue

Jewish Vocational Service, Milwaukee, Wisconsin

INTRODUCTION

For many years, professional disciplines involved in the educational and developmental problems of children have been concerned with the school age child who cannot be taught in a regular classroom because of emotional problems. Research has developed reasonably good techniques for their early identification and diagnosis. Once identified, the children, more often than not, are then excluded from school. If and when they are again ready for school, they return as educational cripples—handicapped educationally in comparison to their age-grade peers—which in turn can lead to further maladjustment. More serious is the fact that most of these youngsters become the nation's "attic" children, a liability to themselves, their families, and the community. The problem of developing a program of education adapted to the needs of these children was faced by the Union Free School District #16, Elmont, New York, which believes in the philosophy that the public schools are responsible for an educational program adapted to the needs of all of the children of all of the people.

Elmont is in Nassau County, Long Island. It is contiguous to Queens and is midway between the north and south shores of Long Island. The greater part of the western boundary marks the dividing line between this school district and the borough of Queens. The unincorporated area in the district is a part of the town of Hempstead. The community is flat, with paved, orderly, treeless streets, and, like many communities in Nassau County, devoid of large open areas for the recreational use of residents.

Elmont's location is such that it cannot be classified as urban or surburban. It is technically a suburb of New York; but in actuality, it is a suburb with many urban characteristics. The community itself is not currently self-supporting, and probably never will be, since there is almost no land remaining for industrial development. The community consists largely of private residences and their supporting neighborhood shopping centers. Since there is no industry (other, perhaps than the Belmont Race Track), most of the residents do not earn their living locally. They commute to New York or to other Long Island areas which have industry. There are some, however, who do live and work in Elmont; for example, a small number of professional men. In addition, a few businessmen live and work in Elmont; but most of the shopkeepers commute from New York City or from other Long Island communities.

There are four community service organizations: Kiwanis, Chamber of Commerce, Lions Club, and Italian Mutual Aid Society; but none of these appears to be a strong unifying influence in the community.

The school district has mushroomed to its present size only recently. Fifty years ago a one-room rural school house adequately served the needs of Union Free School District #16, and the annual school budget at that time totaled less than $1000. There have been several periods of rapid school population growth, each accompanied by increases in school facilities. These occurred in 1924, 1929, and during the post-World War II period, which marked an era of growth that has been equaled by few communities in the country. In the 1930's, there were approximately 2,000 pupils in kindergarten through eighth grade; by 1946, there were 3,000 school children in the district; by 1949, the kindergarten to eighth grade enrollment had reached 3,600; by 1960, there were approximately 6,000 pupils in grades kindergarten through six alone, and another 3,000 in grades seven to nine.

The gross population in Elmont today is close to 50,000 people. As noted above, the vast majority of this population is housed in private dwellings that, at today's market price, would be salable in the $15,000 to $25,000 price range, with a few running higher, and some running quite a bit less. Some of the housing is substandard, especially in those areas found adjacent to the race track, where garages have been converted into living quarters.

As might be expected, Elmont's residents consist primarily of relatively young families who moved from New York City to an area considered suburban to secure the advantages of suburban living for their children. The Elmont School District, certainly in comparison to many of its Long Island and Westchester neighbors, is not an especially affluent one. Its ability to pay for education, as determined by the relationship of its real estate value to the number of students to be educated, is low.

FACILITIES OF THE SCHOOL DISTRICT

To accommodate the special educational needs of pupils with varying degrees of emotional disturbance, this school district utilizes a variety of diagnostic and educational facilities. These include the following:

MEDICAL SERVICES

Each of the seven schools in the district has its own school physician and its own nurse-attendance teacher. There is, in addition, a supervising school physician. As a result of his exposure to the many psychological problems faced by the school district, the supervising school physician has, himself, undertaken a program of further study and training and is now a psychiatric resident at Hillside Hospital. The knowledge and insights he gains there are passed on to the other school physicians who, in turn, can facilitate understanding and communication between the school district and the family doctors of the district's children. There is also a supervising nurse-attendance teacher, as well as a psychiatrist, an otologist, and an opthalmologist, who are available on a part-time basis.

SPEECH AND HEARING SERVICE

The district employs three full-time speech and hearing teachers. They have a direct remedial teaching responsibility for individual children and small groups of children. In addition, they work closely with classroom teachers in order to help them to function more effectively with children who have less serious defects. The speech and hearing teachers also have responsibility for the identification of defects by means of annual speech and hearing tests which are administered to all children.

PSYCHOLOGICAL SERVICES

The district employs three full-time school psychologists and a part-time psychiatrist. Their function is to provide diagnostic and appropriate follow-up services for children who are troubled and to assist parents in obtaining treatment for themselves if they are seen as contributing to the maladjustment of their children. The services of the West Nassau Community Mental Health Center, as well as other welfare, clinical, and family service agencies, are utilized to help implement this diagnostic and treatment program. This team has a preventive responsibility as well, which is discharged primarily through group and individual meetings with principals and teachers for the purpose of increasing their skills in a number of relevant areas. These include methods and techniques for interacting and dealing with children, the establishment and maintenance of good mental health climates in all classrooms, the development of sufficient skills to permit early identification of children in need of psychological services, and a consideration of optimal mechanisms for combining their respective resources in providing service for troubled children.

VISITING TEACHERS

The district employs two full-time visiting teachers. Their function is to work with the permanently and temporarily homebound children of elementary school age. They provide instruction for the homebound child in basic subject areas that parallel the programs of instruction in the same age and grade level in the schools.

ITINERANT TEACHERS

The district employs four part-time itinerant supplementary teachers. They have no classroom assignments. Their function is to work with emotionally disturbed children in the school buildings on a one-to-one or small group basis outside the regular classroom. They do this by providing periods of tutoring and/or remedial instruction similar to that provided by the previously mentioned visiting teachers. They provide instruction in basic subject areas that parallel the teaching program that is going forward in the classroom. These services are scheduled on an individual basis as they are needed.

READING TEACHERS

The district employs three full-time helping teachers with a specialization in reading. These are teachers who work in a staff capacity for the purpose of improving instruction in basic subject areas. They function in a consulting capacity to classroom teachers and in a direct teaching capacity with individual children and/or small groups of children who require remedial tutoring. Among those requiring reading help are a number of youngsters whose academic deficits are quite likely a direct result of an emotional problem.

SPECIAL SUBJECT TEACHERS

The district employs special subject teachers in the areas of art education, music education, physical education, and library services. In addition to their responsibilities to the general school population, these special subject teachers are an important adjunct to the district's program of special adaptations for the child with emotional problems who cannot tolerate a full day in the self-contained classroom and whose program is, therefore, structured to include extra periods of art, music, physical education, library work, etc. The subject matter as well as the close relationship with a special teacher seems to help. The decisions concerning special programming for these children are made on the basis of interdisciplinary staffing conferences which include representatives from all the special services, classroom teachers, and any others whose involvement with the child in question may shed light on diagnosis and/or recommendations.

GROUPING POLICY

The philosophy of grouping in District #16 is to recognize its necessity, but to accomplish it in such a way that the child is not lost in the group. Instead, the grouping itself becomes an instrument, in a limited sense, that helps the child's intellectual and emotional growth. This is accomplished by evaluating:

1. various facets of an individual child's personality;
2. the child's social and emotional adjustment to teachers and classmates;
3. the strengths and weaknesses of the child's academic achievement;
4. the teaching and personality strengths and weaknesses of individual teachers so that, to the extent that it is feasible, each youngster is matched to a teacher who is likely to contribute more to his development than other teachers in the same grade.

The objective, then, in School District #16 is that of "harmonious" grouping, something of a compromise between the more traditional extremes of completely heterogeneous or completely homogeneous groupings. Using such a procedure, there is overlap among groups with respect to ability, but within somewhat narrower ranges than would be the case in a purely heterogeneous grouping system. Therefore, when the building principal and teachers have completed the preliminary work in connection with grouping, the school psychologist reviews the placement of each child to insure the proper implementation of the district's grouping policy. Retentions and accelerations, too, are reviewed individually by the school psychologist.

Despite these not inconsiderable facilities for adaptation and accommodation to the educational needs of children, the school district has in its pupil population, as does every school district, a number of youngsters whose degree of emotional disturbance is serious enough to preclude their progress in normal classrooms and disturbing enough to inhibit the educational progress of the other children in the class. To provide some organized educational facility for these atypical children, the school district embarked on the Project for Disturbed Children.

THE PROJECT FOR DISTURBED CHILDREN

The youngsters in question, generally speaking, are of normal intelligence; however, they are characterized by a more than usual amount of variability. This variability shows up at the level of IQ testing as well as in terms of their day-to-day and even hour-to-hour functioning. Their behavior is oftentimes unpredictable; they are hyperactive, distractible, impulsive, and irritable; they have difficulty in abstract thinking; they are anxiety ridden, emotionally immature, perseverative; usually they are school failures. Not all of these children show all these characteristics, but all show some. It is this fact that makes it unwise to work with them in a normal classroom situation.

District #16 was convinced that special classes were not the answer to this problem. From a characterization of these children, as well as from related literature, it appeared that the kind of program needed would have to be custom made for each child in order to reduce distractibility to a minimum and to establish a one-to-one relationship between pupil and teacher. Group activities would need to be included, and on-going psychiatric and psychological guidance would have to be provided both for children and staff. No school district, including District #16 which is relatively unfavored economically, could afford to provide a teacher for each pupil and the space needed to minimize distractions.

Recognizing these factors and faced with the problem of an ever present group of seriously disturbed children, the district set about to create for the 1959-1960 school year, a specialized program within the established educational framework of the community. The general objectives were to provide each of these seriously disturbed children with an individual education and training program based on his identifiable needs. This program was to be developed around the concept of total programming for seriously disturbed children, using the combined concepts of educational training, psychological identification, and psychiatric insight. If this could be successfully achieved, there would evolve a concept of the educational setting being organized for education, but concomitantly becoming a therapeutic milieu.

To structure such a program became, then, an administrative problem. The task was one of finding several available classrooms and teachers for the six original children (who had been identified as needing this program) on a one-to-one basis, as well as a sponsoring organization to assist with the financial support. The ultimate goal of the educational program was to be individualized training through optimum relationships and final reintroduction of the child to the regular classroom setting without ever totally separating the child from the family or community structure. By providing the necessary specialized program within the context of a one-to-one relationship and preventing the child's exclusion from the community, it was felt that the educational program itself could become therapeutic to the child. A basic premise of this approach is that proper education and training can be a therapeutic process. By working within the established framework of the family and the community, the disruptive effects of separation anxiety which impede progress in residential treatment programs could be eliminated. It was also likely that successfully treated children could be returned to regular classrooms sooner and would be better able to function in a group, free of educational deficits serious enough to constitute a barrier to their adjustment in the normal educational setting.

In casting about for a possible solution, it seemed that all of the potential resources needed for an approach to the resolution of this problem were at hand in the community, but they were either unorganized or under jurisdictions apart from the Board of Education. Since space could not be provided in the schools—there were already 6,000 children in buildings with a rated capacity of 4,800—space would have to be developed elsewhere, and free of charge. As in almost all communities, there were areas not normally used during school hours, e.g., church halls and basements, fire department meeting halls, American Legion dugout, etc. A neighbor, the Elmont Jewish Center, was just completing a building with ten classrooms, an arts and crafts room, a kitchen, a playground, and even an outdoor swimming pool. This seemed ideal. Permission was requested and granted for the use of six classrooms and any of the other facilities which the program needed. The Board of Education agreed to supply transportation for the children, a teacher supervisor, the psychological and psychiatric consultant services, and books and supplies which were normally a part of the district's equipment.

The Elmont Kiwanis Club agreed to sponsor the project and to provide some financial support. For instance, the club paid the premiums to insure the center and the staff from suits should a youngster be injured. The club provided about $600 for special equipment needed, such as the two-sided easels and flannel boards used for each child, electric answer boards, large locked steel cabinets in which to store and secure gear and equipment, and the milk and cookies provided for each child during daily snack periods.

The most difficult problem, however, was how to procure a teaching staff in numbers sufficient to make possible a one-to-one relationship with the children. Furthermore, the kind of people needed—warm, empathic, mature, emotionally stable, and dedicated—are difficult enough to find, even if salary were available. There were in Elmont, as in most communities, women of this kind who have done a good job with their own children and who were in a position to contribute some of their time to community activities. From among such women came the "teacher-moms." No widespread appeal was made for these "teacher-moms" in order to avoid the necessity of refusing the help of people not deemed suitable for working with these children. By personal contact, a number of mothers were invited to contribute two mornings each week to working with a child, the work to be done under the supervision of the professional educational staff and the psychiatric director. These mothers were interviewed by the educational administrator and the psychologists. Every effort was made to discourage them by painting a black picture of what they were about to get into. These interviews provided a good opportunity for the professionals to obtain some insights with regard to the volunteer herself.

It was felt that if two mothers were teamed and assigned to a particular child two mornings a week each, this would come very close to providing the theoretically desirable one-to-one relationship, in addition to being able to account for four mornings a week of instruction. There was no trouble in securing the original twelve "teacher-moms" to start with the original six children. Indeed, the enthusiasm of the mothers for the program was such that it was possible to recruit an initial group of eighteen, with twelve given actual assignments and the remaining six placed on an "on-call" or substitute basis. The program is now expanded to include thirty-eight "teacher-moms," twenty-eight assigned to active status with the fourteen youngsters currently enrolled and the remaining ten in a standby status.

The teams were thoroughly briefed about the child with whom they would be working by the professional staff. They were given appropriate educational materials and a sketchy introduction to teaching methodology, and the enterprise was under way. A teacher specializing at the primary-grade level was detailed to the project to be assisted by the "teacher-moms" as needed, to supervise and coordinate the details of supply, transportation, etc. The school district's psychologists, the supervising school physician, and the psychiatric consultant worked closely with the "teacher-moms" as they began to feel their way in assisting these children toward personality integration and educational development.

As a direct extension of the elementary teacher in charge, the principles to be used by the "primary-grade teacher" and the "teacher-mom" assigned to assist would include: individualization of the program to meet the child's judged psychological, emotional, and educational needs; integration of the child's activities with those of other children in the group to the greatest possible extent; the use of multiple combined modalities such as motor, visual, tactile, and auditory, in the overall teaching process; maximal utilization of a close interpersonal relationship between the child and a warm, interested adult; keeping learning periods brief so as not to overtax the child's limited attention capabilities; providing rewards for appropriate responses; limiting extraneous stimuli; and providing sufficient external controls and limits in order to reduce impulsive acting out behavior in the child. A typical "prescription" which serves as a guideline for the teacher in charge and the "teacher-moms" follows:

Name of Child:	Stevie
Reading:	Weekly Reader 3 and 4 Ginn "Roads to Everywhere" 4th Book Dictionary November—Fingerplays December—Poems Book about Missiles—Science
Social Studies:	Indians, Settlers, and Pioneers
Spelling:	Silver Burdett—Book 4 Language Roundup—Book 4

Math: Modern Arithmetic—Book 4
Manipulative Material

Divided Curriculum: Mrs. N. R. (Teacher-Mom, Mon. and Wed.) will pick up the responsibility for the reading and arithmetic. Mrs. B. K. (Teacher-Mom, Tues. and Thurs.) will pick up the responsibility for reading, spelling, and language book.

Last 15 minutes may be used for outdoor activity. Of necessity this plan must be flexible. Materials will be added and subtracted as progress is noted. Repetition is built into plan.

Psychological:

1. Anticipate his clinging to the work at hand in some areas to the exclusion of other areas, e.g., arithmetic. Skillfully manipulate him toward another area.
2. Stevie may have trouble functioning in the group because he wants to be the center of the group while having ambivalent feelings about it. If he cannot be maintained with these adaptations, he should be removed.
3. Because Stevie, at times, lives in his own world, limits and boundaries must be provided from without.
4. If Stevie appears to be living in his own world, every attempt should be made to bring him back to the reality world.

A typical morning for a child and his "teacher-mom" follows:[1]

The teacher-mom meets her project child as he gets off the station wagon, escorts him to his assigned room and helps him stow his gear and clothing. She then takes him to the "good-morning" room, where the professional teacher-in-charge is waiting to conduct the opening group exercises. These consist of the salute to the flag and a short reading and discussion period. The reading and discussion evolves from what the teacher-in-charge has written on the blackboard, or from "show and tell." She tries to include sentences at the reading level of each of the children which, when put together, make a paragraph about the day's weather, or a holiday or an event, or something with which the children are familiar. Discussion is encouraged. The opening exercises may last a very few minutes or as long as fifteen, contingent upon the manageability of the group that day.

While this is going forward the teacher-mom has secured the books, games, and equipment she plans to use that morning, and is in her assigned room ready to receive her child when he returns from the opening exercises. She sits next to, and close to, the child, and the day's work begins.

She may begin with reading, usually using the reading series and supplementary materials available to the professional teachers of the district. She is encouraged to follow the teacher's manual more closely than a professional teacher, because the manuals are well developed guides and provide comprehensive directions on how to teach the series with which she is working. From reading she moves to other subject areas, such as arithmetic, spelling, language skills, social studies, science. These activities, interspersed at her discretion with games, or talk, or a walk, or listening to records, go forward until 10:30 A.M., at which time there is a snack break. She takes her child to a large room with a long table and benches. One of the children and his teacher-mom have laid out the cookies and milk beforehand—which is done on a rotating basis. All the children as a group sit down and have their snacks under the supervision of the professional teacher-in-charge.

---

[1] Reprinted with permission of The Macmillan Company from *Teaching the Troubled Child* by George T. Donahue and Sol Nichtern. Copyright, © The Free Press a Division of The Macmillan Company 1965.

While the children are having their snacks, the teacher-moms usually assemble in the kitchen for coffee and cookies. Here there is much discussion of the project children, although sometimes it is more social conversation than professional. The snack-time and coffee break takes fifteen or twenty minutes, at the end of which the teacher-mom returns to her room to continue work with her child, following the plan for the day as agreed upon with the teacher-in-charge. If other group activities are scheduled they usually occur during the time between the end of snacks and the end of the morning. At 11:45 the teacher-mom begins to get her child ready to go home. At this point she completes her log of what transpired with the child that day, and leaves it with the teacher-in-charge so that it is available for her teammate teacher-mom.

In the course of the morning she has probably been visited by the teacher-in-charge, who provides on the spot direction and suggestions for furthering the child's educational program.

This is a reasonably normal morning. There are some mornings that are not normal, however, because these children vary in their behavior and response from day to day, hour to hour, and sometimes minute to minute. What the teacher-mom brings to the child is her own emotional climate—that of an affectionate, understanding mother. Her empathy with the emotional needs of the child may result in her altering his academic program, even to the point where it is discontinued. When she senses tension building in the child she is free to lead him away from the academic learning experience by playing a game, taking him on her lap, going for a walk. This leads to a relationship learning experience, which frequently obviates academic or emotional failure for the child. She may even decide to remove the child completely from the structure by taking him to the firehouse, or the post office, or just out on the playground.

She must be perceptive enough not to respond to provocation by the child. Here she may lean heavily on the teacher-in-charge or the psychologist, even to the point of having the other professionals take over completely for a short period of time. Sometimes the teacher-moms have teamed up to handle an acting-out child. In short, the teacher-moms are constantly interfering with the expected, disturbed patterns of these children. This they are in a position to do promptly by virtue of the one-to-one relationship.

She must use her judgment and imagination at times to help the child overcome his academic learning difficulties. The result has been the utilization of some highly unorthodox teaching methods and materials. With the assistance of the teacher-in-charge and the psychologist, because the teacher-mom recognized that the child retained little or nothing of what had been taught over the past few weeks, learning programs have been modified even to the point where a child has been stopped and started all over again. Incentives such as cookies, candy, stamps or coins for a collection have been used. One teacher-mom found that by allowing her project child, a girl, to fix her (the teacher-mom's) hair she could return the child to concentration for another period of time on the learning task. A teacher-mom began to recognize in one child a need to be fed as he was taught, for, as he put it, it was "brain-food." Perhaps for him it was, since by ingesting food and learning simultaneously he was providing himself with two ingredients essential for survival. Another teacher-mom, working with a boy, found that allowing him to stand up and move about helped him concentrate. She even made use of his preoccupation with clocks, not by removing the clock but by keeping one close enough so that his preoccupation was channelized, thereby permitting another part of him to concentrate on reading or arithmetic.

A group activity of about twenty minutes' duration is provided toward the middle of the morning, which includes arts and crafts, music education, physical education, or story time. Other group experiences include the daily snack-break of milk and cookies, and the children's riding together in the school district's station-wagon bus to and from school. Each child's birthday is celebrated by a simple party during snack time. The teacher-moms supervise these group activities on a rotating assignment basis, usually two or three to an activity. Increasing use is being made of the playground facilities for free play and organized games, and seems to be working reasonably well (Donahue & Nichtern, 1965).

The women are accepted as the fourth member of the professional team and are treated as professionals. The theory behind the program is that the teacher in charge will get her work done, as will the psychologist and the psychiatrist, through these women. Close supervision of their work is accomplished by the teacher in charge, who is at the project full-time. She works with the "teacher-moms" individually and in small groups, advising and coaching them. She helps them advance the child's education by evaluating what they are doing and how they are doing it. She is alert to the interpersonal dynamics between the child and his "teacher-mom" and frequently is the bridge between the "teacher-mom" and the psychologist or psychiatrist whom she may contact at any time. The psychologist is scheduled to work at the project one-half day every two weeks, although she is "on call" at all times if needed. The psychiatrist visits three or four times a year, or as needed. Group meetings of the "teacher-moms" are scheduled twice a year with the combination of teacher in charge, psychologist, psychiatrist, and school administrator. But again, this is flexible. If the need arises, a meeting is scheduled.

PROGRAM OUTCOME

Periodic comprehensive evaluation of the children in the program was undertaken, usually at the beginning and the end of the academic year. Such evaluation included: traditional clinical diagnostic procedures with tests such as the Rorschach, Wechsler Intelligence Scale for Children, Bender-Gestalt, Draw-A-Person, and Children's Apperception Test administered by the psychologist; direct observation of the child by the psychiatrist and psychologist; standard educational assessment procedures such as report card grades, achievement test scores, and teacher judgment; and, often times, interviews with parents. These varied data were typically brought together into a clinical conference concerning the child in question, and judgments with respect to progress and disposition were made by participating professional personnel at that time.

Perhaps some of the outcomes of this program can be illustrated by a series of brief clinical resumes presented in the form of case vignettes about specific children. The information provided, in each instance, derives from the sources described above.

D. C.—Male—7 years, 5 months. His diagnosis was schizophrenic reaction of childhood. The situation was complicated by considerable pathology in the total family situation. His mother had been hospitalized for mental illness, and his father was also disturbed. The child developed much better controls, a longer attention span, real enthusiasm for the work and learning situation, and a positive relationship to his "teacher-moms" and some of the other children. His hyperactivity was greatly reduced, and coordination showed marked improvement. He was phased into a regular first grade of twenty-eight children and is now in sixth grade.

B. T.—Female—7 years, 7 months. Her diagnosis was mild cerebral palsy and mental retardation, poor coordination, short attention span, little interest in other children, poor hand-eye coordination, distractibility, and hyperactivity. B. T. progressed to the point that she could handle a pencil and produce basic forms. Her attention span increased, and her interests broadened. She acquired some impulse control, completed the readiness program, learned to identify and write her name, developed arithmetical concepts of most-least, first-last, sequence, bigger-smaller, etc., and left to right progression. She is now successfully functioning in one of the district's classes for the educable, mentally retarded.

J. A.—Male—8 years, 8 months. His diagnosis was schizophrenic reaction of childhood with the severe regressive symptom of soiling. He was hyperactive, harmful to others, and so disruptive that he could not be contained in the regular classroom. In addition, there was considerable family pathology. His parents would not cooperate with the therapeutic proposals offered by the local mental health center. When placed in the educational-therapeutic milieu, this child progressed rapidly, both academically and socially. His soiling ceased. His relationships at home improved. He began to relate well to the other children in the program and was phased into a regular third grade on a half-time program. J. A. is now functioning well in sixth grade.

C. M.—Female—8 years, 1 month. An aphasic child with organic involvement and extensive emotional problems, this child was known to many clinics in New York City as well as to some local mental health facilities which advised that she was completely hopeless and should be totally exempted from school. C. M. was a completely withdrawn child. She now enjoys physical contact. She has improved impulse control and appears to be a happy, attractive little girl who plays with others and occasionally assumes a leadership role. She was initially phased into a second grade, in the middle group in reading in her class, and is now in sixth grade where she is reading on a sixth-grade level. She is anxious to learn and writes and spells appropriately for her age. Most important of all, she speaks—in fact, at times she is a chatterbox. Though not always easy to understand, she has a sizable vocabulary and a desire to communicate.

R. L.—Male—8 years, 1 month. Diagnosed as a schizophrenic child with bizarre behavior, violent at times, he hurt other children, did not participate with the group, did not respond to reasoning, and was egocentric, autistic-like, immature, demanding, given to extreme temper tantrums, and sulking. R. L. was physically large and poorly coordinated. He now has positive relationships with his peers, and particularly with adults. His coordination is improved. He has lost much of his impoliteness and is receptive to suggestions and authority. He tries to play successfully with other children and sometimes shares willingly and voluntarily. He has a high degree of academic ability, particularly in mathematics and science. In mathematics he can solve problems mentally that most of us need pencil and paper to solve. His resistance to reading has been overcome, and he is reading on grade level. He is now in a junior high school program in a residential setting.

C. C.—Male—8 years, 9 months. C. C. was diagnosed as a schizophrenic child who on the surface would appear to be a severe behavior problem. He demonstrated gross distortions in conceptualization and visual-motor perceptualization and extreme uneveness of performance. His deficits inhibited his adjustment in all areas. When he was entered in the special program, it was necessary to start his academic program at the beginning. He needed much repetitition and variety of approach. He progressed to a fourth-grade level and is now functioning with competence in a regular seventh grade; this despite a family with much pathology, including severe marital discord and extreme inconsistencies in the handling of the child.

The children remain in the project an average of two years. One was kept only six months; another, five years. It is always the professional team, i.e., psychiatrist, psychologist and teacher in charge, who make the decision as to when a child has progressed to the point where he is ready to be phased into a regular classroom program. The decision is determined by the child's ability to relate to other children, to his "teacher-moms," and to the teacher in charge. He must be able to sustain himself in group activities, work as independently as some other children in his normal age-grade group, and compete academically with at least some of the other children in the normal group. The psychologist and psychiatrist jointly evaluate the child to determine whether or not enough integration of personality has developed for the child to survive in the normal group setting.

The "phasing-in" is carefully accomplished. A critical factor is the classroom teacher. A decision is made jointly by the psychologist and building principal as to which of the available teachers at the child's age-grade level will provide the optimal circumstances for his development. If in the child's neighborhood school none of the teachers, by temperament, disposition, and method of operating, is thought right for the child, he will be transported to another school in the district where there is such a teacher. No criticism of teachers is implied here because it takes a particular kind of person with the insights necessary and a tolerance level appropriate to work with a disturbed child.

The child might start a half day a week–sometimes on a Friday afternoon when there might be assembly programs or other special activities scheduled. The time is built up as rapidly as the child can take it. Sometimes a child will remain in the project part-time and regular school part-time. Often the "teacher-moms" will be asked to stand by in the school building as the child starts back to regular class so that should he need to be released from the regular classroom, the familiar person is immediately available. A child's schedule can be structured so that, temporarily, he is given some time by the supplementary teacher in the building on a one-to-one or small group basis. Or, he may get extra time with the art, physical education, or music teacher, the librarian, or the school nurse-teacher, depending on his needs.

The building psychologist has the primary responsibility for working closely with the child and with the building staff to help make the child's transition as smooth as possible.

Perhaps the most fundamental evaluative criterion that can be used in a project of this type is the functional one of the child's ability to return to the normal classroom situation and to function effectively in that context. By that criterion some initial success for this program has been achieved. Of the first twenty-one youngsters referred to the program, eleven have been returned to their regular classes and have demonstrated an ability to make normal progress in that setting, both educationally and interpersonally. Given the fact that these are youngsters selected initially because of the extremity of their difficulties and a total inability to profit from the normal educational regimen, preliminary findings along this very concrete dimension are encouraging. Youngsters participating in our program are those who might formerly have been viewed as "unsalvageable"—children destined for continuing, and perhaps increasing, frustration and failure in their school careers. The 50%

"return" rate is an appreciable one for such a sample and seems to warrant continuation and extension of program-development of the type described earlier in this chapter.

What of the "teacher-moms"? What has been the impact on them? They have persisted. During a second year of operation only three of the original eighteen had to be replaced—one for reasons of pregnancy, one with a complicated family situation, and one who just did not want to continue but did agree to act as a substitute when needed. Of the original twelve active workers, seven were with the program after five years of its operation. It is thought that they are deriving a good deal of personal satisfaction from the contribution they are making directly to a child. In addition, they have achieved a certain status in the community because of their participation in the program. This has been more formally recognized by testimonial dinners and some publicity. Perhaps socializing with the other women, too, has helped reduce the separation rate.

They have been treated by the professionals working in connection with these children as fellow professionals and, undoubtedly, have profited in terms of developing keener insights into some of their own problems and of understanding their own children better. While they were untrained people when they started, they have, over the months, acquired a good deal of training in an unorganized way. Coupled with their own intrinsic characteristics, this has greatly increased their stature.

Despite these numerous and substantial gratifications, the program has also presented some very real problems for our "teacher-moms." There has been a transference mechanism operative which, at times, has resulted in the "teacher-moms" identifying with their pupils too closely. Progress with these children has understandably been slow. Sometimes the "teacher-moms" became discouraged and were unable to see the gains being made. Part of the job of the professionals has been to be alert to these reactions and, through group discussions and individual consultations with the "teacher-moms," to help them to avoid having the impact of their experience influence their family and personal lives in an undesirable way.

At times the "teacher-moms" have become somewhat competitive in their zeal to make academic progress with their pupil. This is both desirable and undesirable. It is important that the "teacher-moms" be cognizant of both the need for academic progress and, concomitantly, the need for assisting the child toward more adequate and integrative supervision of the individual "teacher-mom"-child interactions and their development over time.

The program has had a catalytic and contagious impact on the entire community. There has developed a greater awareness on the part of principals and some teachers that successful adaptations to the individual needs of children are profitable and satisfying investments of imagination, time, and effort. There has been a great expansion of their efforts in grouping children so that this or that child is placed with the teacher who, as a particular personality, will provide the optimal conditions for the child's total growth. Some children with problems are now being accommodated by part-time programs weighted with more art, or music, or physical education. In general, the resources of the school district are being mobilized and adapted for accommodating children's individual needs. Teachers are developing not only an awareness but also some skill in identifying, early, children who are in need of specialized help. Most important of all, professional educators are undergoing a subtle improvement of attitude, brought about, perhaps, by greater knowledge, which has led to understanding of children, acceptance of them as they are, and as a result, adaptation to their needs.

CONCLUSIONS

It is believed that the schools can and should adapt to the needs of the emotionally disturbed child. First, the school system in America is the only social institution in our culture which is sufficiently impactful to begin to come to grips, systematically, with the problems of the emotionally disturbed child. Second, it has the advantage of a staff of professional people who are oriented, in part at least, to some of the developmental problems of children. Third, it is believed in this country that separating the severely disturbed child from his normal environment is not desirable for most of these children.

It is true that, given some family situations, professional people would regard the family pathology as being so detrimental that a child would be better off outside the home. But it has been our experience that we have not had to refuse to work with a single child, even when there was a lack of cooperation or a lack of understanding on the part of the family. Despite such circumstances, children get better, although perhaps not so quickly as they might were the family to cooperate and receive from the community agencies the therapy and other kinds of supportive help that these agencies are in a position to give. Some parents are not able to accept outside assistance with emotional problems perhaps because there is, among these people, a fear, *as well as a lack of understanding,* of what the psychologist and psychiatrist can contribute. But, despite all his shortcomings, the educator is in a position in most communities which is not threatening to parents. The educator has a good deal to contribute in assisting people to get to the kinds of help which would be beneficial for them. Therefore, the educator should be provided with the necessary resources, in the school—not in agencies separate and apart from the school.

The shortage of trained clinical personnel has been noted by the American Psychiatric Association (1964), among others. "In the face of the manpower problem, new and creative ways of training semi-professional personnel and volunteers are being developed and should be further explored. They hold much promise, both for mitigating manpower shortages and for improving the range and effectiveness of treatment programs. New types of service are also stimulating new patterns of training" (p. 27). Thus, the use of the volunteer in the Elmont community program fits in with the philosophy and the desires expressed by organizations representing mental health professional groups, including the American Psychiatric Association and the American Psychological Association.

It might be argued that the educative process is itself therapeutic. On those grounds, therefore, the school is a logical locus for mental health programs and has much to offer, especially with the support of psychologists and psychiatrists. The success of such programs will depend upon the educator's acceptance of the responsibility for altering the object of the learning process, the child, in order to enable the youngster to profit maximally from the group educative process. It is not unusual to find a disparity between the intellectual, physical, and emotional developmental levels of youngsters. A child may be six chronologically and intellectually, but only two or three emotionally. Such a youngster cannot be expected to function normally in a kindergarten or first-grade class. Someone must make an effort to reduce this developmental disparity—to enable the child to accommodate to the group situation and to find acceptance in it. This, it is felt, is a proper function of education. It requires, however, that a structure for early identification be developed.

In our school district with its limited psychological services, the work of the psychologist has been concentrated at the kindergarten, first- and second-grade levels; it consists of early identification of problems and the working out of necessary adaptations. It is felt that such an approach will limit ongoing destructive processes in many children, and eventually fewer problems will arise at the upper-grade levels.

One further asset of the educator in dealing with emotional problems is that he is in a position to maintain a focus on the child and to coordinate the efforts of specialized community agencies. The fragmentation seen in the social agency field is a real detriment to bringing effective help to the needy child. Someone must coordinate the functions of diverse agencies so that everything they have to contribute is brought to bear on the specific problem of a given youngster. In this way direction can be provided for all who are dealing with him.

There is little evidence that professionals with a major clinical investment can do such a job successfully. This seems most obvious when one examines the scope of the problem. It is generally estimated that there are one-half million children with serious emotional problems in the public schools. One can add to this figure the 10% of the school population which is estimated by the National Institute of Mental Health and the Mental Health Association to require some professional attention. In the face of such totals it becomes evident that unless some way is devised to use the skills of the psychologist and psychiatrist on a much broader basis than is currently being done, little progress will be made toward alleviating the problem. This implies that such professionals must operate through other nonprofessional and professional people who can implement recommended approaches. The school system may be the vehicle through which such programs are best operated.

The fragmentation of the child and his family through a proliferation of agencies is a condition that needs correcting. The personnel and resources that are ordinarily spent on such agencies might well be put to a more useful purpose if invested in the school system. To be sure, school personnel would require considerable reeducation. The retraining of guidance counselors, principals, etc., by people in the psychiatric field as well as by other mental health professionals might make them capable of coordinating functions so that the child is served most effectively. Perhaps the Elmont project is an example of one form such a program might take.

REFERENCES

American Psychiatric Association. *Planning psychiatric services for children.* Washington, D.C.: Amer. Psychiat. Ass'n., 1964.

Donahue, G. T., & Nichtern, S. *Teaching the troubled child.* New York: Free Press, 1965.

V

SUMMARY

21

EMERGENT APPROACHES TO MENTAL HEALTH PROBLEMS: AN OVERVIEW AND DIRECTIONS FOR FUTURE WORK[1]

Emory L. Cowen
University of Rochester

Whatever has been said thus far is most readily understood in the context of the three principal objectives that have guided this volume. The first aim was to delineate a set of issues which are considered to have prime significance for any searching examination of the mental health problems of modern society. In so doing, some limitations of traditional and historically dominant mental health stratagems and practices have been cited; and an attempt has been made to identify central problems which must be engaged, conceptually as well as concretely, if a sounder mental health order is to emerge. Next, several chapters have been addressed to matters of conceptualization and guiding orientations to mental health problems. Though these reflect differences both in the aspect of the total problem to which they are targeted and in the substance of the viewpoint represented, they encompass a spectrum of possibilities which may have heuristic value for implementing specific mental health programs. And, finally, descriptions have been presented of a number of concrete program models, varied in objectives and in substance, but sharing as a common denominator the attempt to introduce fresh, new approaches to basic and long-standing problems in the mental health area.

Viewed against this backdrop, there may now be merit in trying to get some distance from specific chapter contributions so as to: (1) achieve a type of preliminary consensus concerning the underlying issues raised in the opening chapter, (2) crystallize alternative models and their implications, (3) develop a frame of reference and a sense of direction for future work, and (4) highlight those questions which are still open and must be engaged if the emergent approaches orientation is to be pursued in an optimally effective manner. In contrast to the problem-defining posture of the first chapter, the present one emphasizes the expression of a point of view. Indeed, the phrase "point of view" may be little more than a socially desirable euphemism for a network of systematized biases and prejudices.

---

[1] The author wishes to express his sincerest appreciation to his friend and colleague, Dr. Melvin Zax, who, during the course of his sabbatical stay at the Kommunehospitalet in Copenhagen, Denmark, made important substantive and editorial contributions to this chapter. Moreover, some of the ideas expressed herein have evolved over a number of years marked by close interaction, research collaboration, and discussion of issues and practices in the mental health fields with him.

SCOPE OF THE PROBLEM AND PROFESSIONAL RESPONSIBILITY

Any responsible effort directed at overcoming the mental health difficulties of modern society should start with a reaffirmation of the enormity and complexity of the problems that confront us. Illustratively, there is good reason to suppose that the principal help-oriented techniques utilized in the past are limited in their clinical effectiveness. Of even greater concern is the fact that such techniques are limited in their reach, most often according to the rule that those who most require help find it least available. Moreover, we are grossly deficient with respect to the availability of technology for engaging vast segments of our population whose mental health needs have remained essentially unmet. By and large, we have ignored or repressed these lacunae or have felt helpless in approaching them. And, not the least of our problems is the fact that professional manpower and resources in the mental health sphere, either in the present or in terms of the most optimistic extrapolations into the future, are woefully inadequate for the task at hand. Accordingly, the issue seems less that of making a case for the magnitude of this particular set of problems and more that of making decisions about optimal starting points toward their resolution.

Inherent in the foregoing remarks is the conviction that concern with mental health problems cannot, and should not, be the exclusive responsibility of any single discipline or professional subgroup. Taken together, the helping professions, as presently defined, represent a numerically weak and poorly equipped army. That their efforts might be further diluted by squabbles of possession and prerogative, "brush-fires," and internecine warfare can only guarantee a disastrous backsliding for the total mental health operation. In this vein, we would emphasize that the present volume, not accidentally, transcends professional lines both in editorship and authorship, reflects viewpoints bearing on mental health problems from responsible professionals sharing a common focus on such problems, whatever their disciplinary fields, and seeks to avoid parochial identification.

There is need also for a sobering reminder that the helping professions, even assuming that they represent a welded and homogeneous force, are not themselves in a position to be the sole contributors to knowledge about and solutions for mental health problems (Cottrell, 1964). There should be an important place for theoretical and empirical contributions from other relevant disciplines, including physically oriented ones such as biology, biochemistry, and neurophysiology, and socially oriented areas such as education, economics, political science, and sociology. In fact, it is appropriate to go one step further by pointing out that the very concept of "helping professions" may be little more than an artificial abstraction growing out of a mental health orientation that begins at the point of pathology and focuses on subsequent rehabilitation. In that sense the actual term *helping professions* is better understood as a product of historical accident rather than as one which has an intrinsic logical justification. It is conceivable that future patterns of mental health programming, professional interdependencies, communication, and cooperation might sooner involve a combination of *some* members of the presently constituted helping professions together with sociologists, educators, political scientists, and economists, rather than the historically typical *intra*-helping profession team of psychiatrist, clinical psychologist, and social worker.

CONCEPTUAL APPROACHES

It would be gratifying to have available a master plan which one might hope to apply, with reasonable confidence, to the resolution of our major mental health problems. Unfortunately, such a blueprint does not exist; and we must expect much ambiguity as we strive to move from the level of ideas to that of concrete action. Perhaps the principal tools now available are those of logical and conceptual analysis buttressed, only to a minimal extent, by beginning indications of supporting empirical data.

Perhaps the most central need in the mental health area at this time is that of conceptualization, since program definition, implementation, and articulation, as well as much of our research effort, should rest logically on such a base. This point has already been given considerable emphasis in the chapters by Albee, Turner and Cumming, and Reiff. Many of the shortcomings in our present mental health structure may reflect either the fact that we have overlooked underlying conceptual issues or that our partial and implicit conceptualizations have not been in tune with social reality.

Although the importance of the conceptual elements of the total problem cannot be overemphasized, we do not mean to imply that there is a unified and dominant conceptual orientation that characterizes the chapters of this volume. Indeed, if there is a common denominator, it will be found, structurally, at the level of dissatisfaction with aspects of our present mental health order and in terms of attempts to deal in innovative ways with problems that have been refractory to traditional approaches. Substantive programs described in this volume have not, necessarily, started from a base of systematic conceptualization. This is entirely understandable! Programs often develop in response to relatively concrete needs or unresolved problems as these arise in particular settings. Their profile and format are determined, to a considerable extent, by the structure and subculture that characterize those settings. Conceptualization is sometimes explicit, but perhaps more often implicit.

Moreover, the enormity of our mental health problems is such that no single program can be expected to grapple with them in their full complexity at this time. Accordingly, even those who have been concerned with conceptual issues have gravitated toward partial conceptualizations geared to salient aspects of specific programs. Our failure to have identified a comprehensive and agreed-upon conceptual "leitmotif" in this volume should, therefore, be regarded as neither surprising nor alarming. Since the current state of our knowledge is so limited, there is ample need for exploration, trial and error, and probing the limits of varied approaches, even where underlying conceptualizations are, at best, partial and implicit. Maximal utility from a *systematic*, conceptual orientation may be expected to derive at the level of long-range and global mental health planning, since it will help to establish needed priorities and to point up relatively more promising courses of action within a social framework where limited resources must be allocated with particular judiciousness.

At the risk of oversimplification, it may be said that there are two principal models that warrant prime consideration for their pertinence to mental health problems. The first of these may be called the medical model; the second, the public health or preventive model. It would be incorrect to suppose, notwithstanding the availability of ready stereotypes for each of these concepts, that preference for one or another model corresponds to one's membership in a particular professional group. Such is not the case, either within the relatively limited confines of this volume or in the world at large. If we were to study the conceptualizations and belief systems of mental health professionals, we would find individual psychiatrists, social workers, and psychologists who, in the factorial sense, are closer to each other than they are to colleagues in their respective professions. Perhaps because of this, some issues can be better drawn, in that disagreement and conflict can follow ideological, rather than professional, lines. As Reiff cogently remarks (Ch. 5), "A power struggle on the basis of ideology can be an important catalyst for institutional change" (p. 86). Since ideological or conceptual models appear to be so important for the mental health fields, a more specific examination of such models is in order.

THE MEDICAL MODEL AS APPLIED TO MENTAL HEALTH PROBLEMS

There has been no necessary unanimity in past usage of the term medical model, and in speaking of it, various writers have emphasized different of its attributes as salient (Bloom, 1965). Indeed, the very concept itself is a somewhat projective one that conjures up a spectrum of images ranging from the highly laudatory to the entirely pejorative. Specific reference to one or more aspects of this model has appeared in many of the chapters of this volume, and detailed consideration of it is presented in the chapters by Albee and Turner and Cumming.

Certainly one broad notion which is central to the extended usage of the medical model concept in the mental health sphere is the belief that emotional and psychological disorder may be regarded, structurally, much in the same way as physical illness or dysfunction. An extension of this belief, perhaps caricatured, is to be found in the popularized and somewhat overworked cliché that mental illness is the same as any other illness (Joint Commission on Mental Illness and Health, 1961).

Though the foregoing principle is basic to the model, there may be differences in the level of literalness with which it is espoused. In a more narrow sense, emotional disorder may be viewed, quite specifically, as a *disease* involving specific biological, chemical, or physiological pathogens. Such is a "disease model," and those subscribing to it place heavy emphasis on curative interventions involving chemical, surgical, shock, and other types of physically-based therapies. In addition, research stratagems, given this view, are directed toward the development of more effective therapeutic agents within this same genus. For others, still within the framework of the medical model, a given pathological condition, be it an anxiety neurosis or schizophrenia, may be viewed as a type of "illness" without recourse to literal assumptions about its disease nature or its etiology. It is quite possible, for example, to view the determinants of current malfunction as largely psychological in nature and therefore accessible to psychologically-based ameliorative procedures, such as psychotherapy. In either case, there is a focus on pathology or on ineffectual functioning. There is the tacit assumption that the pathogenic source must be identified through utilization of some combination of tools from our diagnostic armamentarium and that a type of remedial intervention, be it physical or psychological, must be directed toward the elimination or reduction of that source.

Though not necessarily defining characteristics of the medical model, several other of its attributes should be noted as logical derivatives. Given a primary focus on pathology, it follows that the model is largely passive-receptive in its social stance. People with intrapersonal difficulties, when they become sufficiently unhappy or their functioning reaches a certain point of ineffectiveness, seek out, or are brought in for, help. At such a moment there is the tendency to view the helping professional as both knowledgeable and authoritative, much as the physically sick individual views his doctor. Moreover, expectancy and, indeed, actual practice is such that subsequent diagnostic and therapeutic contacts involving the helper and the person seeking help proceed largely via the same one-to-one pattern that characterizes the clinical interaction between a physician and his patient.

At several points in this volume, particularly in the introductory chapter and the chapter by Albee, detailed consideration has been directed to the question of why the medical model has emerged as the dominant ideology behind our approaches to mental health problems. This evolution has been multiply determined. In the first place, the very earliest general "practice of medicine" grew up in response to concrete needs of people who had physical (or emotional) problems which perturbed them or others around them. Unlike the physical sciences, mental health practices did not develop out of a curiosity to understand nature's intricacies. For the individual, as long as his body (or mind) functioned properly, there was little impetus to think about medical phenomena. Accordingly, the earliest precursors of the medical model grew, quite logically, as the response of a few relatively perceptive members of primitive society to the acknowledged needs of other members of that society. The earliest healers invoked magical incantations and their spiritual powers and probably had some success. Only over a period of many centuries has there been a gradual replacement of the primitive practices of the healer by scientifically-based alternatives. In particular, the marked advances in physiological and biological research in the eighteenth and nineteenth centuries resulted in the conquest of disease entities which, up to that time, had been totally enigmatic (Bloom, 1965). The physician was provided with the means for far greater success, and the use of the age-old model was sharply reinforced. The healers' magic had become quite formidable.

At the same time, an intellectual climate was developing which was strongly reinforced by the early psychoanalytic movement and was characterized by a growing concern about psychological dysfunction, again in response to the complaints of people with troublesome symptoms. The potential conquest of emotional disorder took on the qualities of a new and exciting frontier. Under such circumstances it is not surprising that a model which had had astonishing success and seemingly limitless potential in a related area should have been seized upon to fill the vacuum in the psychological sphere. This is especially so since it was a model with which medical men were familiar and one that seemed to fit certain situations with which they were grappling. Certainly it was to be preferred to the prior mystical and spiritualistic explanations of maladaptive behavior. Moreover, for many decades alternative ideologies about mental health problems simply did not exist because our perceptions of what such problems entailed had not yet changed. We have, therefore, been in a prolonged "proving period," with this particular set of conceptions guiding mental health operations in our society.

Criticisms and Limitations

With the growth and evolution of modern society, the success we have experienced in overcoming physical disorders, our ever-increasing ability to meet physical and material needs, and technological advances making for more comfortable living and increased leisure time, we have entered an era where higher-order concerns about the emotional well-being of man, concepts of his optimal functioning, and self-actualization have come increasingly into focus. Otherwise stated, we have identified new types of problems in the mental health realm. We have moved steadily, in recent years, toward the conviction that a "square deal" with respect to mental status is desirable for everyone—not just a luxury for the enlightened few. That this has been something more than idle philosophizing is well reflected in concerted social planning at the highest and most influential levels. Huge sums of money have been allocated and many new programs have been implemented seeking to improve the emotional well-being of members of our society—including those who do not clearly perceive such problems in themselves.

One aspect of this significant social trend has been the implicit need to scrutinize, as realistically as possible, the pros and cons of prior mental health programs and operations. As a result of this process, it has become more apparent—its contributions and merits notwithstanding—that there are fundamental limitations to the scope and effectiveness of the medical model which require careful reexamination.

First, it is necessary to recognize that, in most instances, the etiology and nature of psychological disorder is fundamentally different from what is involved in physical disorder (Schofield, 1964). Emotional problems do not characteristically result from tissue damage or invasion by viruses or bacteria. Rather, they are likely to reflect complex psychological determinants and multiple sources of influence deriving from exposure to key social institutions and important "others" in the individual's life experience. That currently manifest psychological problems may have long-standing and deep-seated determinants is more likely to be the rule than the exception. If we take as an example a twenty-five-year-old adult experiencing severe current emotional disturbance, one way of looking at such a person is to say his lifetime has extended some 200,000 hours—much of this living potentially under the influence of profound daily irritants and pathological processes. As a basic long-range mental health stratagem, is there genuine reason to believe that a given treatment approach, whether it extends over 10 hours or 100 hours, should be viewed as the method of choice in seeking to alter an already well-entrenched style of life and ineffectual mode of adaptation? In the sense of long-range social planning (choice of models), could we not be more optimistic if we were able to orient ourselves to an understanding of the influence systems and social processes that underlie presently observable unfortunate outcomes, to modify such systems and influence processes, and to build positively beforehand rather than being restricted largely to a type of after-the-fact "counterpunching"? The fact is that this same orientation can be, and is, developed in medicine—particularly public health medicine—when its concerns turn to issues such as the maintenance of the general health of the public or stemming the development of epidemics.

The magnitude of this concern is multiplied by certain additional considerations. Helping professionals, as they presently define themselves, are in no position to look for troubled people. Instead, people seek their help—via the hospital, clinic, or consulting room—when personal difficulties reach alarming proportions. Often, because of financial considerations, lack of readily available professional services, social stigmata, or personal anxieties about the meaning and implications of seeking professional help, the level of disturbance at the point such help is sought may be profound. The moment of initial contact or action by the professional is, therefore, likely to be when symptomatology is rather well entrenched and morbidity relatively advanced. It must seriously be questioned that such is the optimal time for intervention. While the focal challenge-point for utilization of the medical model in the mental health sphere lies in the breakdown of its implicit assumption of an analogy between psychological and physical disorder (i.e., in its application to types of problems for which it was not developed), this, in no sense, is the sole basis for social concern about it.

A further order of criticism is to be found in a cluster of factors which may be encompassed under the umbrella of "limited scope." This cluster includes at least three separate dimensions. In the first place, the medical model—based as it is largely on the one-to-one clinical interaction—is a very costly one from the standpoint of professional manpower. We simply do not have a sufficient number of helping professionals to provide mental health services for those who need it; and future extrapolations, as Albee has so amply demonstrated, indicate clearly that this disparity is likely to become exacerbated over time. In this sense, it is fairest to think of this model as a hold-the-dike operation at the very outside. A second dimension of the "scope" argument has been stated earlier. The medical model is intrinsically a passive one which engages disorder only when disorder seeks it out. For this reason it necessarily fails to have impact for tremendous numbers of individuals with psychological disorder because, for any one of a score of reasons, their problems are not well enough defined to prompt them to seek assistance within that framework. And third, there is the issue of restrictions in scope imposed by limited technology. It has been strongly emphasized in the chapters by Reiff, Riessman, and Gardner that the form, "lingo," and *modus operandi* of the medical model, in its typical implementations in the mental health sphere, are so alien and meaningless to potential consumers in vast segments of our population that there does not exist a basis for even initial, superficial contact. It is as if there were no overlap in ground rules as these are defined by the helper and potential recipient, and there is consequently no basis for "playing the game." Effectively, this means that mental health services have, until very recently, been defined, functionally, as out-of-bounds for the poor.

There remains yet another set of considerations, somewhat beyond those of assumptions and scope, which constitute a final important component of any assessment of the medical model as it has operated in the mental health arena. These pertain to its effectiveness, and are, perhaps, less a critique of the model itself than of the forms in which it has been implemented. No one would argue, even in the relatively more denotable areas of physical disorder, that the operations and practices of the medical model have been 100% successful. This much granted, our "batting average" in the mental health sphere —using any reasonable criteria—has been far lower. Two types of failings should be noted. First, fundamental entities of disorder—for example, schizophrenia—have proved largely resistant to curative assault. Although our ability to maintain some patients in the community has improved in recent years, for many patients, once a certain point of pathology has been reached, the expected prognosis is still that of languishing for the remainder of one's days in a custodial setting. Second, for many types of emotional disorder we have come to attach a savior quality to psychotherapy which has caused it to be oversold for both the buyer and the seller. Presently available data offer little support for the assumption that psychotherapy and its variants hold the key to the resolution of major mental health problems of modern society. It appears to be a limited-effectiveness approach in which the prognosis is best for the healthiest, for those who might best be expected to recover without it.

A qualitative ditinction of some importance may be made between criticisms relevant to the assumptions of the medical model and those pertaining to its scope or effectiveness. In the latter two cases, what is essentially implied is that the model is a sound, albeit fallible, one which must be modified in certain ways for more effective results. Phrased otherwise, one might say that the medical model is a viable model but that we have failed to dispense the correct "medicine." The major order of business then becomes that of searching for, trying out, and evaluating new "medicines" (approaches) for problems that have not yet been addressed or have heretofore been dealt with ineffectively. When, however, its fundamental assumptions and tenets are challenged, alternative ideologies are implied which would lead to qualitatively different approaches and to a different order of "practice."

Clearly, one discernible emphasis in recent years, within the mental health field in general as well as in this volume in particular, has been on the need to shore up the medical model at a number of its vulnerable points (Joint Commission on Mental Illness and Health, 1961; Williams, 1962; Glasscote, Sanders, Forstenzer, & Foley, 1964). We have come to recognize increasingly the need to explore briefer treatment approaches for their potential positive values as well as to extend the scope of existing resources. Implicit in this development has been some shift in focus from the level of psychodynamics to that of actual behavior. We have also accelerated efforts to increase the likelihood of having contact with disorder earlier in its history and at a point of lesser morbidity. This appears to be a prime objective of the Joint Commission Report and the Community Mental Health Act of 1963 and is the guiding motivation behind current efforts to establish a network of community mental health centers around the nation. There has been a greater willingness to try out new and flexible adaptations of technique in an effort to reach the heretofore unreachable. Such a statement, while intended primarily to refer to the mental health approaches with the poor, is sufficiently broad to include other new developments such as learning theory-based applications to behavior modification.

We have witnessed concerted attempts, in many directions, to improve both the continuity and reality-basis of traditional treatment approaches. The isolation of mental hospitals from the community (Goffman, 1961) is being eroded at multiple levels. New hospital construction is designed, geographically and structurally, to facilitate two-way access between patient and community. There is a growing emphasis on the integration of treatment and living to the fullest extent possible. Day hospital and night hospital approaches, halfway houses, home-visit networks, and programs of aftercare, each represents an effort to adapt treatment to the existing potential and resources of the individual and to aim for his earliest possible restoration to adequate functioning in the community (Williams, 1962; Bellak, 1964a; Greenblatt & Levinson, 1965).

A substantial effort has been made to provide mental health helping services in institutional settings—courts, prisons, schools, enforcement agencies, etc.—where such services were, in the past, unknown. And there has been a growing climate of receptivity about using new sources of manpower, often nonprofessionals, in ancillary roles. This reflects the objectives of freeing the trained professional for higher-order functions and of extending the reach of mental health helping services.

The foregoing endeavors, individually and collectively, represent attempts, largely within the framework of the medical model, to improve the scope and effectiveness of our mental health operations. As such, they are to be encouraged. Though the medical model has clearly not solved all of our problems, it represents an effort to meet with a class of very real problems that must be engaged. While it is easy to sit back and take potshots at the model, it would be irresponsible to dismiss it. We are called on to deal with the present problems of gross emotional dysfunction and will be called on to do so for as long as we can see in the future. No approach gives promise of eliminating psychological disorder altogether, and many instances of malfunction will continue to slip through even the most efficient of conceivable dragnets in the future. Moreover, democratic and humanitarian considerations dictate that continuing, serious effort be directed toward the amelioration of manifest disturbance. Given the fact of psychological disorder, the types of recent developments we have witnessed should be regarded, potentially, as a more flexible and constructive implementation of the medical model—or, to use our earlier analogy, better "medicine."

THE PREVENTIVE MODEL AS APPLIED TO MENTAL HEALTH PROBLEMS

It is largely when the distinction is made between existing problems and optimal long-range planning and stratagems in the mental health sphere that limitations of the medical model are highlighted. This model has, for decades now, been implemented by highly skilled professionals, people of good faith, working with energy and devotion. But it has not resolved, nor does it give promise of resolving, our major mental health problems. Even though improvements may be found in methods of treatment, and even though cure rates for certain disorders may slowly edge up, there is little basis for believing that society today is "healthier" than it was a century or two ago. To the contrary, with the conquest of physical disorder, increasing awareness of the nature and vagaries of psychological dysfunction, and the population explosion, it is fair to assume that problems of emotional perturbation are, in the absolute sense, of greater concern today than they have been in the past (Sanford, 1965a). Moreover, if we remain on what has been our historical course, such problems give every promise of increasing, rather than decreasing, in the future.

The critical gap in our struggle to conquer psychological disorder resides in our long-standing orientation to issues of cure as opposed to those of genesis or flow. While this historical inclination may be entirely understandable in terms of the needs and pressures to do something about visible, palpable disorder, there can be, at best, only limited long-range promise to any system that does not accord central prominence to the problems involved in cutting down the flow of disorders—i.e., to issues of prevention. There should be little basis for disagreement with the foregoing principle as an abstraction.

More concretely, however, even within the limits of the present volume, we may identify those who regard the preventive approach as a replacement for the medical model as opposed to those who view it as a needed supplement. Preference for one or another of these alternatives is probably a function of whether one focuses almost exclusively on long-range planning or addresses himself simultaneously to both present problems and future planning. In either case, the realities and the demands of our present mental health situation place the highest priorities on the need for explicit conceptualizations aimed at delineation of the attributes of a comprehensive, preventively-oriented mental health model. The following preliminary effort in this direction may be regarded as something of a conceptual credo for this volume.

Systems-Centered Operations

To fulfill the promise of the preventive orientation, there is a central need to view the primary institutions of society as key targets for concerted, mental health-oriented endeavors. Mental health problems must be regarded as logical derivatives of a particular social context; in the broadest sense, they are interwoven with the very fabric of society. Such a view inevitably underscores, once again, that mental health-relevant actions and interventions may not be regarded as the exclusive bailiwick of the helping professions and poses a series of questions which should assume focal importance for professional specialists. These are the following: What is the nature of the primary institutions of modern society? In what ways do these institutions affect human development, particularly personality and emotional development? How can influential social systems be modified? What types of modifications are related to what types of outcomes along dimensions that are considered to be most critically relevant to mental health problems? Obviously, these are complicated and profound questions which will not be resolved overnight. Indeed, in the present volume, there is perhaps only one chapter—that of Zimiles—which begins to approach them directly.

Given this orientation, certain shifts in emphasis and transformations in roles for the helping professional emerge as logical consequences. For one thing, it seems highly desirable that a greater proportion of his total effort be spent in work with social systems rather than in one-to-one contacts with troubled individuals. Intrinsically, such a shift carries with it the potential for involving many more people in our mental health operation, both as purveyors and recipients.

Second, it is important that the professional adopt a problem-engaging, problem-seeking stance as opposed to his traditionally passive, problem-awaiting posture. The potential ramifications of such a change in orientation are substantial. A system of practice which begins when problems show up carries with it an implicit focus on the aberrant and the pathological and suggests that the prime objective of our helping operations is the restoration of the individual after malfunction has been identified. Certainly this bias may be detected in the things that fledgling helpers are taught during their graduate training and in the types of clinical experiences to which they are exposed in their clinical practicum and internship activities. An ideology which focuses exclusively, or primarily, on pathology allows us to do little more than tread water, and sometimes, not even that.

A generalized shift by the helping professions to what we have described as a problem-seeking stance implies a new and different set of roles. For one thing it suggests a greater emphasis on early detection of disorder in the life cycle of the individual, combined with interventions designed to forestall aggravation of the particular condition. More fundamentally, however, it suggests that we turn our attention to human assets and resources, toward attempts at building psychological strengths, and toward the circumvention of pathology before it develops. This point of view has not gone unrecognized! Hollister (1965) grants it so much importance that he has coined a new term—*stren,* defined as "an experience in the individual's life that builds strength into his personality" (p. 31). It is his belief that we need such a concept to "help us to focus more of our efforts on the challenge of building strength . . . rather than devoting the major part of our time to repairing the impact of traumas and maldevelopment" (p. 31). Aspirations we may have to work systematically on the problems of building resources and psychological strengths rest primarily on our approaches to primary social institutions, rather than on what can be achieved in the consulting room, and depend, quite focally, on the adaptation of a problem-engaging orientation to mental health issues. Implied is the belief that a successful long-range program designed to build for psychological health would reduce to more manageable proportions the restorative efforts required when more advanced pathology is identified. Logically, it would seem that this type of approach has much greater promise for breaking the vicious societal circle and for elevating our efforts in the mental health sphere to something more than the "holding operation" that they have been.

In view of the foregoing considerations, there is need for a shift in orientation from the office, clinic, hospital, and consulting room to the community and for a greater willingness to engage psychological problems in their natural habitat. This point merits further comment, even at risk of digressing, momentarily from the principal argument. The terms *community psychiatry, community psychology,* and *community mental health* are very much part of our current *Zeitgeist.* They are, without question, "in" concepts. But they are also ill-defined ones as Glidewell (1966) succinctly observes: "The most aggravating thing about community mental health is its expansive, vague, nebulous and varied definition" (p. 33). Critics of this movement (e.g., Dunham, 1965) have decried, with considerable justification, the tendency of professionals to rally around the community "banner," sometimes quite uncritically, in what may represent little more than the substitution of a new and poorly understood champion for an old one. The title of the recent paper "Community Psychiatry: The Newest Therapeutic Bandwagon" (Dunham, 1965) is to be understood in this context. The community approach has been an amorphously defined, mammoth inkblot which has allowed people to infer whatever they wished to infer. This has been facilitated by a social and professional climate which accords the community an increasingly central role and particularly by recent appropriations of huge sums of money earmarked for community-relevant programs which pertain directly or indirectly to mental health problems.

It should therefore be emphasized, in the strongest terms possible, that a simple transplantation of existing mental health practices to new community settings is likely to result in little progress and serious disappointment (Kelley, 1966). *Function,* not locus, is the critical element, and the potential shift of our mental health operations to a community base should be a means rather than an end. Inherent in such a shift are the opportunities to study more relevant and meaningful questions, to extend the reach of mental health operations, to look at resources rather than deficits, and to develop specific mental health programs with greater social utility. Without recognition of the salience of these functions, there is the danger that the community approach will, in the final reckoning, offer little more than the oft-maligned "old wine in new bottles." One of the most telling criticisms that can be leveled at the Community Mental Health Act of 1963 is that its specifications for "essential services" may be so tightly drawn that they preclude the possibility of genuinely transcending long-established, sometimes well-rutted, mental health practices.

Reorientation of our mental health focus from the office to the community offers considerable potential for approaching the vast, unresolved problems of reaching the heretofore unreached—particularly the poor. Much has been written in this context in recent years (Duhl, 1963; Brager, 1964; Riessman, Cohen, & Pearl, 1964; Beiser, 1965; Pearl & Riessman, 1965; Peck, Kaplan, & Roman, 1966; Sarason et al., 1966), and four chapters in the present volume—those by Reiff, Riessman, Klein, and Gardner—are specifically addressed to issues of conceptualization and implementation in this area. Once again, the message that comes through is that a mere transfer of traditional helping services (no matter how substantially these may be increased) to more accessible community locations is doomed to failure. Our critical needs in this area revolve much more around "how" questions than "where" questions. Thus, matters such as definition of what constitutes mental health services for this group and optimal modes for delivery of such services are of central importance. Answers to the latter questions should be predicated on the fullest possible understanding of the way in which the poor see their problems (Reiff, Ch. 5; Clausen, 1966).

Both Reiff and Riessman have emphasized the deep-seated alienation experienced by people from the lower socioeconomic classes vis-à-vis the mental health professional and his practices. Fundamental concepts of what is health and what is pathology differ sharply between the poor person and the helping professional, as do definitions of psychological versus moral problems. For the poor, needs are experienced largely as immediate, practical, crisis-related, and physicalistic rather than in terms of futurism, neurotic suffering, higher-order functions, and actualization. Moreover, preferred modes and loci of interaction differ for the poor person and the typical helping professional. All of the foregoing adds up to a gross deficiency in what Riessman calls the "style-match" between the frame of reference and *modus operandi* of the helping professional and the needs and problems of the poor. Recall the concluding remarks in Reiff's chapter which are highly relevant here: "The task is to develop concepts, methods, programs, and services that are appropriate, effective, and related to the life styles of low-income people and to their needs, in a way which will create an effective demand for them. This will require significant institutional changes" (p. 87).

To a considerable extent, the posture of the helping professional in his work with the poor has been: "This is what I have to offer! Can you use it?" —and the answer has effectively been, "No!" Hopefully, by shifting the focus toward the more fundamental questions of "How do *you* see your problems?" and "What do *you* need?" we may be able to develop a more realistic basis, using Reiff's words, "to convert the very great existing need into effective demand for services" (p. 74).

It should not be assumed, however, that delivery of services is the sole or fundamental problem that we face in mental health work with the poor. The present situation of this group is such that a more basic thrust in the direction of primary preventive actions must constitute a central component in our long-range planning (Fantl, 1964). Deutsch (1964) discusses this issue as it applies to educational approaches with the poor and the need for their revision in the light of what we are coming to know about life styles and preferred modes of interaction of this group. The more general point is underscored by both Reiff and Riessman. Indeed, the latter, in his description of the Neighborhood Service Center program (Ch. 10), makes it quite explicit that provision of services is largely an instrumental function designed to engage the poor. Hopefully, this initial, meaningful type of contact will establish the building blocks for "increasing social cohesiveness" through community action and, ultimately, for initiating institutional change.

There may be some merit, at this point, in bringing in a thread that has appeared several times thus far. With our emphasis on the need for a mental health system of broader scope, a focus on the community and its primary institutions, activity rather than passivity, and an effective system for delivery of mental health services to the poor, greater dignity is accorded to operations oriented to visible, palpable, everyday behavior touching many, as opposed to an intrapsychic, psychodynamic approach which has been a luxury of the few (Clausen, 1966; Rae-Grant, Gladwin, & Bower, 1966). Whether our concern is defined narrowly in terms of behavior modification or broadly in terms of social system modification, there is little reason to believe that formal psychotherapy is the best or only way to achieve such ends. As Klein (Ch. 9) has intimated, a decent and meaningful job may be the best of all therapies for some individuals. This is a simple example of the larger problem of skill deficit in this group and the utilitarian value of training in skill acquisition and coping techniques (Beiser, 1965).

Moving away from the specifics of mental health programming for the poor, attention should next be given to the question of what are the natural habitats for preventive work? In general, it can be said that the appropriateness of a given setting is a function of the breadth and depth of its influence on people. By these criteria, two primary institutions in society—the family and the school—share certain unique characteristics which suit them particularly well for the task. First and foremost, they exert profound and enduring influence on the child in his formative stages of development. The bulk of his time for many years is spent in one or the other of these two settings. The way he comes to see his world, and the people in it, is largely determined by what he experiences in these settings; and his most influential identification models will be found there as well. Thus, both the family and school suggest themselves as prime, face-valid targets for preventive endeavors.

At a practical level, however, certain considerations favor the school as the more promising of the two settings, in the foreseeable future. Not the least of these considerations is the fact that the school is a geographically intact entity—a system which provides access to large numbers of individuals simultaneously. Difficult and complex as it may be, the prognosis for establishment of a meaningful preventive program for, let us say, 500 children housed under a single school roof and monitored through a single administrative organization may be considerably better than trying to work individually with these 500 families in their separate homes. From the standpoint of likelihood of cooperation, comprehensiveness of program, demands for professional time, facility of management, availability of relevant contributory personnel, or potential for formal evaluation, the control and manipulability of the school situation make it a more sensible starting point for systematized approaches to mental health problems. This is not to downgrade the importance of the home as a determinant of human development, particularly personality development; the opposite (i.e., recognition of the prime importance of the family) is closer to the truth. Hence, the present bias is to be defended largely on pragmatic rather than logical grounds. Parenthetically, it should be noted that schools may represent the most promising avenue for a systematic approach to families. Preventively oriented school mental health programs would do well to keep this possibility firmly in mind. This point is illustrated in the chapters by Morse and Gildea, Glidewell, and Kantor, and elsewhere in the literature (Brim, 1961; Glidewell, 1961; Hereford, 1963; Klein, 1965).

The attractiveness of the school as a focus for preventive mental health programs has long been recognized, and much has been written on this subject (Caplan, 1956; Krugman, 1958; Gildea, 1959; Glidewell, 1959; Allinsmith & Goethals, 1962; Lambert, 1965a; Torrance & Strom, 1965; Sarason et al., 1966; Westby-Gibson, 1966). In fact, in the present volume, eight of the substantive chapters are devoted to varying types of school programs. Each of these represents a departure from traditional mental health services for school children beset by emotional difficulties or ineffective functioning. Anchoring these approaches at one extreme is the social systems analysis approach of Zimiles—a precursor to primary preventive work. A second approach is that of Roen, who has directly infused mental health-relevant content into the curriculum at the fourth-grade level. Upgrading the competence and knowledgeability of teachers with respect to the mental health area has been the special focus of Morse, while Gildea, Glidewell, and Kantor have attempted to work with parents in this same area. Programs of early identification and early secondary prevention have been emphasized by Iscoe, Pierce-Jones, Friedman, and McGehearty and by Zax and Cowen. And, finally, two special types of early secondary prevention with more seriously disturbed youngsters have been described by Lewis and Donahue. Each of the latter two is predicated on the assumption that an optimally effective educational regimen is also likely to be personally helpful—indeed, therapeutic—for the child.

In short, the school, as a pervasive and highly influential social system which affects the lives of all people in our society, represents a most promising field of operation for prevention programs. It is a system that can be approached in very primary ways—for example, through teacher training (Allinsmith & Goethals, 1962; Sarason, Davidson, & Blatt, 1962) and curriculum modification (Biber, 1961; Ojemann, 1961; Allinsmith & Goethals, 1962)–and it has vast and as yet hardly explored potential for early detection and early secondary prevention of emotional disorder (Cowen, Izzo, Miles, Telschow, Trost, & Zax, 1963; Bower, 1965; Hollister, 1965; Lambert, 1965b; Sanford, 1965b; Cowen, Zax, Izzo, & Trost, 1966a).

Because of the conviction that system-relevant preventive actions should start, wherever possible, with institutions that have maximal impact, initial consideration has been directed to the family and the school. That these two settings are "logical firsts" should not obscure the fact that there are other agencies and institutions with potential for preventively-oriented mental health activities. Among the more obvious of these are courts, detention homes, prenatal and well-baby clinics, settlement houses, and community centers (Peck, Harrower, & Beck, 1958; Leighton, 1960; Spiegal, 1964; Sarason et al., 1966).

People-Centered Operations

While we have spoken, centrally, to the need for an order which places greater emphasis on system-relevant activities, this is not to say that people-relevant interventions are immaterial. With realistic limits to our total mental health resources, however, it may become increasingly important for the professional to attach priorities to the many admissible people-centered functions. Using potential impact once again as the guide, two broad principles are suggested. First, people-oriented interventions should occur at times of maximal impact. Two constructions, both intended, can be placed on this principle—the first, in terms of the nature and chronology of a given episode; the second, in terms of the life history of the individual. Second, in our people-oriented approaches we need to focus on those individuals in society whose everyday functions place them in an influential position vis-à-vis mental health problems. If it were possible to capture, using single words or brief phrases, the issues reflected by these principles, the appropriate terms would be "crisis," "early childhood orientation," and "care-givers." Each bears some elaboration.

Crisis

The concepts of "crisis theory" were introduced by Lindemann (1944) following his studies of grief reactions among those who survived the disastrous Coconut Grove fire. It was his impression that certain potentially deleterious consequences of such experiences could be circumvented by appropriate actions of key figures during the crisis period and that there were important implications to be drawn from this for mental health preventive work. Others (Caplan, 1960, 1961, 1964a, 1964b; Bower, 1964) have further articulated this concept and discussed its relevance to the broader area of prevention. Crises are defined as relatively brief periods of transition and disturbance which, by their very nature, require adaptations that are important in the mental health sense. The salient subjective attributes of the crisis situation for the individual include a sense of ineffectiveness or helplessness in coping with the problem, vacillation and disequilibrium, a heightened susceptibility to influence by others, and concurrent emotional upset. These are caricaturizations of what theorists have elsewhere described as "new psychological situations" (Lewin, 1936; Wright, 1960; Meyerson, 1963). Crises of two general orders can be identified—normal, developmental crises (Erikson, 1959) and accidental crises reflecting "life hazards involving a sudden loss of basic supplies, the threat of loss, or challenge associated with the opportunity for increased supplies accompanied by heightened demands on the individual" (Caplan, 1964a, p. 35).

All people experience crises and, almost by definition, the manner in which the crisis situation is resolved will have implications for one's mental health status. Successful crisis resolution may contribute to future immunity, whereas failure to resolve the crisis is likely to increase vulnerability. To a considerable extent crisis outcome depends on the types of choices that the individual can perceive and the guidance available to him during a relatively brief critical period. The crisis situation is therefore one of unusual influence potential, and the choices and decisions made by the individual can be modified in constructive ways through the participation of significant others in the resolution process (Caplan, 1964a). One of the implicit hopes residing in the establishment of community mental health clinics is that problems which normally appear as entrenched pathology may be engaged earlier, in a crisis phase, when the potential for constructive influence of outcome is much greater.

Important as crisis intervention may be, it should not be regarded as a "savior" notion. Indeed, given our underlying philosophy, it represents an approach with some noteworthy limitations. Though all people experience both developmental and accidental crises, they do not experience the same number of crises, with the same intensity, or with the same outcomes. Thus, far short of the concept of crisis intervention, there are those whose conditions of life, exposure to influence systems, and personality makeup insulate them against occurrence of crisis or its deleterious sequelae thereafter. The study by Ladieu, Hanfmann, & Dembo (1947), in which it was found that the best predictor of adjustment to amputation was the pretraumatic adjustment level of the individual, supports this argument.

Implicit is the conviction that there are significant phenomenological determinants of what is crisis and what is not, not unlike those identified by

Lazarus (1966) in his discussion of the stress state. Crisis, in its raw form, need not therefore be accepted as an eternal and immutable "fact of life." Caplan himself (1965a) reflects this awareness when he identifies and speaks of the importance of "training in crisis coping" (p. 12) and "anticipatory guidance or emotional inoculation" (p. 18). The essence of these approaches is to anticipate crisis, to arouse it as vividly as possible in analogue form and under relatively nonthreatening circumstances, and to offer practice and guidance in coping. Hopefully, such experiences may contribute to the development of an immunity which will help the individual to handle real-life crises more effectively.

Quite beyond this fascinating specific technique, however, primary preventive work, involving constructive modification of influential social systems, might well be expected to reduce, spontaneously, the incidence, severity, and negative consequences of crises. Put another way, one objective of long-range mental health planning should be the reduction of the "flow of crises" as well as the reduction of the flow of pathology. That the former will not be fully achieved, even in the best of worlds, is the basis for according a relatively high priority to crisis intervention among the many potential people-centered approaches.

Early Childhood Orientation

Maximally impactful intervention times for people-centered mental health activities may be approached from the framework of the life history of the individual, as well as from that of mediating crisis. This notion rests upon the view that the young child is more flexible and malleable than the adult and that the early childhood period is one of maximal potential for the modifiability of the organism (Eisenberg, 1961, 1962a). Such modifiability should be interpreted broadly to include the potential for building resources and strengths through the influence of impinging social systems, as well as the amelioration of defect resulting from the earlier life experiences of the child. The first of these potentials is the one of primary prevention, the centrality of which has already been underscored on several occasions in this discussion; the second is that of *early* identification and *early* secondary prevention which remain to be considered.

In our view there is neither mutual exclusiveness nor intrinsic contradiction between an early childhood orientation and one which emphasizes crisis intervention. This position is not shared by Caplan (1964b) who says: "The basic model for prevention is no longer that of intervention early in the person's life history. This is superseded by intervention in crisis situations at any phase of life" (p. 6). By his choice of the word "superseded," Caplan implies that early childhood intervention and crisis mediation should be regarded as alternative approaches to the same basic problem. Our own preference is to view these orientations as potentially supportive of each other (e.g., "training in crisis-coping," "emotional inoculation"). If there is any conflict between them, it is primarily in emphasis and how (given very real limitations in our total mental health resources) priorities for scarce professional time should be allocated. For the moment, such choices are largely value judgments; ultimately, we might hope that they could be made on the basis of empirical evidence.

It would, however, be misleading to dismiss Caplan's preference for crisis intervention over early childhood intervention as a specific or circumscribed one. Instead, it reflects a disillusionment and sense of pessimism which many people feel about the cumulative impact of our mental health efforts with children—a much broader issue. Such disenchantment is epitomized in a statement by Hunt quoted in the Joint Commission Report (1961). "Our hopes of preventing mental illness by mental health education and child guidance clinics have been disappointed, and there is no convincing evidence that anyone has ever been kept out of the state hospital by such measures" (p. 71). These sentiments are echoed by Caplan (1964b), who cites the collective failures of child guidance clinics and argues that treatment of children may be more time-consuming and less effective than similar work with adults. Indeed, considerable support for this position is found in the critical review of the literature by Levitt (1957) on the effects of psychotherapy with children. Insofar as this particular type of intervention is concerned, results have not been especially encouraging.

Still another set of arguments has been advanced which speaks against a child-centered orientation in our mental health efforts. As Allinsmith and Goethals (1962) have pointed out, though they do not support the position, there are those who believe that the emotional problems of young children are basically ephemeral and transitory and that they may not be regarded as meaningful predictors of psychological difficulties later in life. Otherwise phrased, it might be said that most emotional problems of early childhood are part of a normal developmental sequence and that youngsters will, by and large, outgrow them in due time. Indeed, data have been presented recently (Onondaga County School Studies, 1964) which lend some credence to the argument. Implicit in this view is the further belief that amelioration of dysfunction early in the child's history does not substantially alter the likelihood of his success in dealing with subsequent difficulties. What is called into question by this position is the wisdom of the ancient aphorism "As the twig is bent, so grows the bough" as this might be applied to the understanding of human emotional development.

Though empirical evidence on this issue is, unfortunately, sharply limited, it is at least possible to point to some relevant data, a good deal of which derives from school settings. Recent extensive work directed toward the development of techniques for the early identification of ineffective functioning in the young school child, reported by Bower and his associates (Bower, Tashnovian, & Larson, 1958; Bower, 1960, 1961; Bower & Lambert, 1961), has facilitated study of such problems. A later series of investigations (Cowen et al., 1963; Zax, Cowen, Izzo, & Trost, 1964; Cowen et al., 1966a) has shown that children with manifest or incipient emotional problems, diagnosed on the basis of social work interviews with parents, group-testing, and classroom observations at the beginning of the first school year, are, at the end of three school years, doing considerably more poorly on almost any type of criterion measure used than are their intellectually comparable but emotionally healthier peers. These criteria reflect a broad spectrum of the child's functioning, including achievement indices such as report card grades or standard, system-wide, achievement tests; behavioral measures such as attendance and nurse referral data; and self ratings, peer ratings, teacher ratings, and personality tests reflecting adjustment. It seems probable, at least within the three-year period of development covered by these studies, that the child with early-identified emotional difficulty does, in fact, get started on a course which moves him rapidly downhill in most of the significant areas of his school functioning.

That such early dysfunction may have some predictive meaning for the child's later career is suggested in the findings reported by Cowen, Beach, Izzo, Laird, Rappaport, Trost, and Zax (1968). These investigators followed up children with early-identified emotional difficulties, from their original studies, and found that a similar pattern of ineffective functioning still differentiated them from their peers, four years later, as they were getting ready to enter high school. In like manner, Stennett (1965) applied a modified Bower screening technique for identification of emotional disorder to fourth-, fifth-, and sixth-grade children and identified some 22% of his sample as either moderately or seriously handicapped emotionally. The central question with which he was concerned was: "To what extent are the adjustment problems of these emotionally handicapped youngsters self-healing?" (p. 445). Follow-up over a several-year period suggested that the emotionally handicapped group fell increasingly farther behind their peers with the passage of time, leading the author to the following key conclusion: "A significant number of children identified as emotionally handicapped are not likely to resolve their adjustment problems without help. For this group 'emotional handicap' should be viewed as a 'disease' and not a 'phase'" (Stennett, 1965, p. 448).

Another series of investigations approaches this same issue on a more long-range basis and in terms of "bellwether" clinical criteria. In a comprehensive study, O'Neal and Robbins (1958a, 1958b) followed up, after thirty years, a sizable group of individuals who had been seen for comprehensive evaluation around some type of problem behavior in the mid-1920's. At that time the average age of the subject group was twelve years, and all had had psychometric evaluation and an adequate clinical work-up. A control group of 100 youngsters, problem-free, and matched for age, sex, race, and IQ, was also studied. The incidence of pathology at the adult level for the "problem-child" group was quite high, particularly in terms of the categories of sociopathy, psychosis, and alcoholism. Indeed, only 21% of the group was considered to be problem-free—the comparable figure for the controls being 60%. In further detailing these findings (O'Neal & Robbins, 1958b), evidence is presented indicating that those who later became schizophrenic had histories which were characterized by significantly more symptoms, particularly antisocial ones, more areas of disturbed function, more hospitalizations, and more arrests than their "problem-child" controls. Support for these findings is found in the investigation by Bower, Shellhamer, and Dailey (1960), who report significantly poorer high school mental health and school record ratings for a group of Ss who later became schizophrenic, in comparison to their nonschizophrenic controls.

Also based on the retrospective approach, but using somewhat less extreme criteria, the recent important study by Westman, Rice, and Bermann (1967) is pertinent to the issue we have been considering. Having at their disposal detailed and excellent records of behavior starting at the preschool level and close later follow-up, these investigators found a correlation of .88 between maladjustment ratings dating back to the child's early school career and the utilization of mental health clinical services over an eighteen-year period. As in the case of the three prior studies, these findings indicate that early emotional difficulty does not generally dissipate spontaneously and that it seems to predict fairly well to later difficulty. Relevant to the "twig is bent" assumption, these authors conclude: "The evidence obtained in this follow-up study contradicts the time-honored notion that children outgrow behavior problems seen in early life and supports the thesis that drastic shifts in manifest behavior tend not to occur during the first eighteen years of life. Children with adjustment problems in nursery school tend to have adjustment problems in later school life, and these problems tend to be of the same order" (Westman et al., 1967, p. 728).

The findings of the studies cited above are consistent and mutually supportive. Collectively, they give pause to those who see no special merit in directing a major portion of our mental health effort toward children. Though there clearly are such things as the normal developmental problems of growing up as well as other atypical difficulties that will be overcome spontaneously, many emotional problems of early childhood are danger signs which meaningfully predict to later, perhaps more serious, troubles. We are in need of a fuller taxonomy of such early childhood difficulties—those about which we should be concerned as well as the less serious ones. Moreover, we may not regard screening or detection as an end in itself. Rather, they should serve to identify the targets of new types of programmings and interventions which aim for early secondary prevention at a time when the flexibility and modifiability of the organism augur well for the potential of constructive change.

That there have been serious shortcomings to our prior corrective efforts with emotionally disturbed children cannot be denied. Such failures, however, do not justify focusing our mental health efforts elsewhere; rather, they suggest that we have not yet identified maximally effective approaches and methodologies for work with this vitally important age-group. As indicated above, our basic hopes for significant forward movement in this area reside in social system modification and primary prevention. Beyond that, however, recognizing that there will be continued need for people-centered mental health activities, our belief is that a prime focus of such activities should be upon the young child and his environment. This particular bias is shared with Smith and Hobbs who, in a recent position paper (1966) have stated: "... fully half our mental health resources—money, facilities, people—should be invested in programs for children and youth, for parents of young children, for teachers and others who work directly with children. This would be the preferable course even if the remaining 50% were to permit only a holding action with respect to problems of adults" (p. 505).

We should be reminded by this quote that undifferentiated use of the broad-gauge concept of secondary prevention in the mental health area may be quite misleading. In fact, the concept covers two distinct, and perhaps factorially unrelated, components: preventive interventions which occur early in the ontogenetic history of the organism and those which take place relatively early in the chronology of a current episode. Much of the force of the present Community Mental Health Center movement is directed to the latter (Glasscote et al., 1964). Though this, *per se,* is to be preferred to traditional patterns of tertiary prevention, knowledge of the nature of human development, the learning facility, and the modifiability of the young suggests that the most meaningful contribution of the secondary preventive approach may reside in that component which involves early intervention in the individual's life history (Eisenberg & Gruenberg, 1961). For similar reasons, while one may welcome crisis intervention as a significant addition to the armamentarium of people-centered helping techniques, it would be both premature and indefensible to view this as a replacement for an early childhood orientation.

Care-givers

It is, by now, a well-established fact that only a relatively small percentage of people who see themselves as having personal or emotional problems requiring outside assistance take those problems to mental health helping specialists. A convincing basis for this statement may be found in the data of one of the subreports of the Joint Commission series, that of Gurin, Veroff, and Feld (1960), entitled *Americans View their Mental Health.* Based on a series of questions directed to a stratified sample of American adults, it was found that roughly 25% of all respondents had, on one or more occasions in their lives, felt the need for help with an emotional problem and that some 15% had actually sought it out. What is most germane, however, is the fact that less than 20% of those seeking help took their difficulties to members of the helping professions. Rather, the preponderant majority of calls for assistance were directed either to clergymen (42%) or to physicians (29%).

The preceding statistics are limited to people who recognize a personal problem and who request formal help. Without question, there are many others in objectively similar circumstances who do not seek such help. Various reasons may account for this, for example, ones of definition or ideology with the poor, or fear of stigmatization, whether due to conscious or unconscious determinants; however, the result is to inhibit solicitation of outside help. Thus, it is somewhat ironic that while there are not enough mental health specialists to meet existing, spontaneously crystallized demands for their services, at another level such specialists are not the ones who are called on to deal with most mental health problems. The professional "carries" only a limited fraction of the "total national caseload" in the area of psychological dysfunction (Schofield, 1964).

We may assume that mental health-relevant experiences, problems, and sometimes, crises are ever-occurring aspects of human existence. The structure of society ordinarily provides people with readily available lines of approach for dealing with personal unhappiness or ineffective functioning. Without attaching the formal label "I need help," individuals are capable of resolving many difficulties through commerce and verbal interaction with family members, friends, colleagues, neighbors, or respected others who are part of their natural environments—ergo, the oft-maligned bartender or hairdresser. It is fortunate that such outlets exist since, in many instances, they not only work effectively but they also constitute a first line of defense against more chronic dysfunction. All of us have doubtless had the experience of contact with individuals who are particularly helpful. Were our society entirely populated by such, the need for the professional helping specialist might well be obviated.

There are circumstances, however, where spontaneous first-line resources are either not available or insufficient to cope with a given set of difficulties. At such times, the individual is likely to seek help, in either an open or veiled fashion, from any one of several trusted, authoritative, influential people in his life space—most often professionals, but not mental health specialists. Caplan (1964a), in his insightful discussion of this problem, has defined the latter as "care-givers," i.e., people who are "agents of the community in fostering the well-being of a citizen and in helping him deal with unfavorable circumstances" (p. 50). Schofield (1964) refers to them as "invisible therapists." Care-givers may be in this position either because their traditional roles involve dealing with crisis or because they have prolonged and close contact with individuals. As noted above, Gurin et al. (1960) have found that the prime exemplars of these two categories are physicians and clergymen. In addition, special mention of the care-giving functions of nurses, pediatricians, lawyers, school principals, and teachers should also be made. Whether they choose to do so or not, such care-givers are often called upon to deal with mental health problems that troubled people thrust upon them. Their actions and handling of such situations will, by design or otherwise, affect the emotional well-being of the individual in potentially significant ways.

As Caplan (1964a) has pointed out, although our societal care-givers have, in recent years, become more sensitive to and sophisticated about emotional perturbations and their potential interactions with other strands of the person's existence, "their functioning is not traditionally designated in regard to its effect on the mental health of their clients" (p. 50). These professionals are trained to deal with some delimited segment of the individual's complex existence—a segment which does not include his psychological problems. In practice, however, the extent of involvement of the care-giver in mental health problems, when he is confronted with them, is likely to vary considerably as a function of his personality makeup, his training and experience, his opinions and attitudes with respect to mental health matters, and oftentimes, quite concretely, the availability of alternative resources in the community.

For whatever reasons then, the care-giver becomes enmeshed in the personal problems of human beings. His is an impactful role in our total mental health operation: He can be helpful or harmful depending on his personal attributes and sensitivities, background and orientation, and the ready availability of competent "backstopping." Rather than denying this evident reality, our problem becomes one of utilizing professional mental health resources so that the effectiveness of the care-giver can be maximized. Indeed, it should be recognized that in many ways the care-giver is in a better position to deal with emotional difficulty than is the mental health professional. He encounters problems closer to their natural habitat and considerably earlier in their chronological sequence, and he often enjoys the trust and confidence of the individual seeking help. Both of these factors are related to the effectiveness of mental health interventions; neither can be dismissed lightly!

The mental health professional can make an extremely important contribution, working within the framework of social reality, by supporting the care-giver, whatever the latter's culturally-defined role may be. The principal method recommended by Caplan (1964a) for provision of support to the care-giving professional is that of mental health consultation. It is beyond the scope of the present discussion to consider, in detail, the many aspects and potential formats of such consultation. This has already been done elsewhere thoroughly and effectively (Caplan, 1959a, 1961, 1963, 1964a, 1965c; Kazanjian, Stein, & Weinberg, 1962; Haylett & Rapoport, 1964; Spielberger, Ch. 12). It is sufficient here to note that mental health consultation for the care-giver is designed to provide information and suggested alternatives in circumstances which go beyond his experience or competencies, to help him to achieve a fuller recognition of the mental health implications of a variety of situations which are encountered in his typical practice, and to establish a backstopping, resource relationship which may allow him to approach mental health problems with a greater sense of security or confidence.

The attractiveness of mental health consultation with care-givers resides in its geometric potential. Care-givers, by definition, have high-influence contacts with large numbers of individuals. Illustratively, a group consultation arrangement, involving one mental health professional and, let's say, a dozen or so pediatricians, could conceivably affect thousands of individuals—children and their families—in constructive ways. Moreover, those contributions to the effectiveness of the care-giver which are made through consultation around a single incident potentially carry over to his subsequent, everyday work.

There are certain situations in which consultation with care-givers may be the only available approach to mental health problems, either currently or in the foreseeable future. This is true in impoverished, rural, and geographically isolated areas or in small urban centers that are devoid of professional mental health services. Another of the subreports comprising the Joint Commission series (Robinson, DeMarche, & Wagle, 1961) indicates that the almost complete unavailability of professional mental health resources in many such places around the country constitutes a problem of considerable proportions. In such settings, the physician, clergyman, or teacher is forced to double as a mental health specialist, since there is no viable alternative. The immediate problem is that of helping well-intentioned, sometimes struggling, individuals to establish competencies in dealing with mental health situations that are far beyond their know-how and their overtaxed resources. Effective mental health consultation has much to contribute in this direction. In this volume, Spielberger (Ch. 12) has described a consultative program aimed at professional care-givers in a small urban community in the South which lacked professional mental health personnel. Here, group mental health consultation was the method of choice due to limits upon available consultative time and specific positive attributes of this approach. Elsewhere, Kiesler (1965), Huessy (1966a), Libo and Griffith (1966) report a number of different mental health consultative activities applied in various geographical regions, each characterized by insufficient professional mental health services.

For the most part, professional care-givers become involved in people's personal difficulties because they are brought to them voluntarily—whether in blatant or subtle form. There are people other than care-givers who, by virtue of their positions in society, necessarily come into frequent contact with people in crisis, and do so under circumstances which could have potentially important mental health reverberations. Policemen, sheriffs, judges, welfare investigators, bartenders, beauticians, barbers, and truant officers are in this category. Kelley (1964) has used the term "urban agents" to describe such individuals. Though contacts with such community agents often arise in informal, unsolicited, and entirely unpredictable ways, this does not negate their influence potential. In other words, the concept of mental health consultation, though highly relevant to the professional care-giver, need not be limited to him. It may be hoped that the mental health specialist can also come to have increasing impact on this second category of involuntary, situational-influence agents through the medium of his community-based educative and consultative functions. In this manner urban agents may, as Kelley (1964) suggests, become . . . "important mediators between the larger population and the formal health and welfare resources" (p. 479).

Most discussions of the potential of mental health consultation with care-givers (e.g., Caplan, 1964a) emphasize that the particular value of working with such individuals resides in their proximity to important crisis situations and in their ability to exercise a constructive influence in crisis resolution. Though this is undoubtedly true, it should not obscure another, perhaps even more significant potential of the care-giver, who may be provided with a set of unique opportunities to work toward the building of psychological strengths and the fostering of resources in individuals with whom he has contact. The critical role that the care-giver plays in the total mental health operations of modern society indicates the need for systematic augmentation of mental health practicum and educational experiences as part of the training of all those who, realistically, will be called upon to deal with such problems in their professional careers (Bellak, 1964c; Caplan, 1964c; Sheeley, 1964).

To return to our earlier criteria, professional care-givers, as people who are capable of extending the reach of our mental health activities to a very significant degree, should certainly constitute a central focus for people-centered interventions within a largely preventive framework.

Problems and Limitations

We have attempted, in our consideration of a preventive model, to provide a unifying conceptual analysis and philosophical credo which may serve as an aid to long-range planning in the mental health fields and provide some impetus for the development of new approaches and programs. It seems clear to us that this is a much needed emphasis, whether conceived of as an alternative or as a supplement to traditional and historically dominant models. That there are significant indications of evolution in this direction is evident from many of the chapters of the present volume.

Whatever the promise of prevention, we must also recognize that there are limitations to the approach and obstacles to its implementation. For one thing, it is characterized by the quality of nonpalpability, and it is largely future-oriented. Typically, mental health operations start with visible and immediate suffering. Just as the allure of fund-raising campaigns for childhood diseases such as polio, cerebral palsy, or muscular dystrophy comes from posters showing a young (usually quite attractive) child in braces, on crutches, or in a wheel-chair, so does the allure of mental health fund-raising campaigns and the allocation of funds for mental health-related purposes come largely from knowledge of the plight of the severe psychotic. This vital ingredient, certainly for the lay public—and perhaps for a number of professionals—cannot be readily envisioned in contemplating prevention programs. Further, the immediate cost of such programs tends to be high since they utilize expensive professional personnel over relatively long periods of time. Understandably, there may be a reluctance to support activities where immediate payoff cannot be seen, where long-range benefits have intangible qualities, and where there is little prior empirical basis to expect positive outcomes.

Perhaps the strongest counter to such a reservation is to be found in certain types of other cost accounting figures which are rarely considered by the lay public. For example, it has been noted (Duggan, 1965) that it costs $4,000 to process just one adolescent through the juvenile court system in New York City and that the average cost to a large urban community for high school dropouts who end up on welfare is approximately $30,000 per individual. Certain types of residential treatment for emotional disorder cost upwards of $15,000 per year. And, in the extreme case, a lifetime of simple custodial care for a single psychotic patient in a state hospital may cost the taxpayers up to a quarter of a million dollars. All this is far short of the social value questions lurking behind the relative apportionment of monies to national defense and space exploration in contrast with mental health expenditures. These considerations underlie the present view that the mere promise of a preventive approach is sufficient to justify its support—especially considering the failures and shortcomings of our cumulative prior mental health efforts.

The interacting arguments of cost and unproven quality do not exhaust the list of potential deterrents to the establishment of preventive programs. A series of such deterrents has been identified and cogently discussed by Bower (1963, 1965). One is the complexity and enormity of the social problem we face, which is a source of pessimism, if not total defeatism, for many. At a less extreme level, for most professionals there is an aura of ambiguity attached to the prevention area, characterized by a lack of understanding of its specific aims and objectives, its relevant parameters, and its means-end contingencies. And, even where there is some clarity on the foregoing matters, since the area itself is largely uncharted, professional specialists are unclear as to how perceived ends may be achieved. The absence of ready-made technology can easily lead to a sense of threat and to an undermining of one's professional security. These types of difficulties can only be eroded gradually over time through the establishment of academic and field training programs designed to plug presently existing gaps.

Bower (1965) also notes that critics of prevention programs have spoken of them as a kind of meddling or as invading human privacy. In response, he argues that although primary prevention does touch upon the lives of individuals before they are singled out as needing special help, it may be regarded as a "necessary and, indeed, mandatory step for common good" (1965, p. 2), very much as we now regard a smallpox vaccination. Far from meddling, as Eisenberg (1962b) has pointed out, prevention is at least as much the responsibility of the helping professional as contaminated water is the problem of the microbiologist or lead base paints that of the pediatrician.

Community agents, care-givers, and mental health specialists, because of their job descriptions and the nature of their day-to-day interactions with other human beings, inevitably touch upon the emotional well-being of others in significant ways. If such people fail to act under these circumstances, they have acted! If they act inappropriately, they have also acted! The real choice does not, therefore, seem to be one of action versus inaction; rather it is one of inappropriate or random action versus maximally informed and expeditious action.

To be sure, there will be very real problems in the establishment of a preventive framework as a genuinely meaningful one. But, perhaps it is time for those interested in mental health problems to accord a somewhat more central position to the philosophy that "an ounce of prevention is worth a pound of cure." Certainly the promise of ultimate savings in human misery, as well as in dollars, is more than enough to justify such an emphasis.

NONPROFESSIONALS IN MENTAL HEALTH ROLES

Whatever the conceptual model one chooses to adopt, it seems evident that the mental health problems of modern society cannot be adequately handled by existing professional resources (Felix, 1962; Nichols, 1963). Given the heavy new demands for professional specialists placed upon us by the establishment of a nationwide network of community mental health centers and population extrapolations viewed against our potential for training additional helping professionals, the already existent trend suggests that our shortages will become greater over time (Albee, 1963). Amplification of our mental health manpower structure is urgently required, and our need-increments in this regard are more nearly geometric than arithmetic. While partial resolutions of this difficulty might emerge from new conceptualizations which, through modification of our fundamental approaches to mental health problems, could ultimately relieve some manpower pressures, there is immediate need for the recruitment and training of nonprofessionals and subprofessionals for mental health functions.

Having made this judgment, many questions and ramifications pertaining to the philosophy and mechanics of their utilization suggest themselves. In our further consideration of these issues, two central and recurrent themes appear basic. First, the way in which nonprofessionals are utilized must reflect the types of conceptualizations we hold about an optimal mental health order. Second, it must reflect the needs and attributes of a specific setting or program. In that sense few absolute "rights" and "wrongs" can be categorically enunciated.

Volunteers have performed a variety of functions in the mental health area for many years. Historically, however, such work has all too often been characterized by a "hit-and-run" or menial quality. Fundamentally, this is not what we are talking about here. The nature of our mental health activities is such that a meaningful and stable relationship—a committed human relationship—is often at the core of things. Several implications derive from this. First, there must be genuine involvement and a substantial ongoing commitment in time by the worker. This, in turn, suggests that careful attention be given to problems of recruitment, training, and supervision of the nonprofessional. Second, his roles and functions should be meaningful ones—not simply passing out chalk, putting test scores in a grade-book, pouring tea, or scrubbing blackboards. With the crystallization of new roles for the nonprofessional, there is a parallel need for rethinking and reconceptualizing the roles and functions of the professional, leading potentially to a very different sort of helping structure. The latter aspect of the problem will be considered more fully below, in the section on professionals.

Before we can address matters pertaining to the recruitment of nonprofessionals for mental health roles, we must deal with a prior, somewhat hidden, issue. When troubled people are helped through human interaction, does such help stem primarily from the intellective and training attributes or the personal characteristics of the helping person? Over the years the helping professions have placed their bets on the first of these two clusters and have set up their advanced specialty training curricula accordingly. Graduate training is long and arduous, involving the learning of theory, the accumulation of fact, and the acquisition of practical experience. There is surprisingly little evidence, thus far, to indicate that these are the attributes that predict meaningfully to success in modification of human behavior or in helping people. If the elements that make one an effective helper are other than intellective training ones, then, insofar as advanced professional training is aimed at producing helpers, a great deal of our efforts may be for naught. It is entirely conceivable that the natural endowments or helping reflexes of many nonprofessionals may equal or exceed those of the professional. On a strictly logical level, this argument would seem to justify intensive exploration of the nonprofessional's utility in mental health roles. In addition, need and parsimony combine to make the issue immediate.

A recent, highly significant study (Poser, 1966) suggests that the foregoing considerations are neither academic nor abstract. Poser compared the effectiveness of entirely naïve college undergraduates and experienced professionals—largely psychiatrists and social workers—as group therapists with chronic, hospitalized adult male schizophrenics. The students were totally untrained; few had had a single psychology course, and none had any expressed interest in future mental health careers. They were hired as part-time employees to do a specific job. By the same token, the professionals were clearly qualified and competent people, highly trained and with many years of professional experience.

The patient sample used in the study was a well-defined and sizable one. All of these were chronic cases with a minimum of three unbroken years of hospitalization prior to the start of the study and an average of fourteen years of hospitalization in all. Patients were assigned, following appropriate matching procedures, to a control group (no therapy) or to a student-led or professional-led therapy group. With 10 patients per group, there were 13 student groups (N = 130), 15 professional groups (N = 150) and 63 controls for a total of 343 Ss. Few restrictions were placed on the therapists in either group, other than to have them all try to promote interaction among the patients. The contact between both professional and lay therapists and their patients was not at all superficial. With daily, one-hour meetings extending over a five-month period, each group recorded well over 100 sessions.

The effects of therapy were evaluated by a comprehensive battery consisting of six psychomotor, verbal, and perception tests frequently used with schizophrenics (e.g., reaction time, word association, tapping speed), administered on a preexperiment-postexperiment basis. Any mismatch on these variables was partialed out using covariance methods.

The principal findings of the study were clear-cut. Treated subjects, whatever their specific group assignments, improved significantly more than untreated ones. However, within the treated group this improvement was uneven; those seen by lay therapists registered greater gains than those treated by professionals. This was the case directionally for five of the six measures, with the differences, favoring students, highly significant on three (speed of tapping, *reaction time,* and verbal fluency). Moreover, the changes brought about by these untrained therapists proved to be stable over a three-year period, as demonstrated through follow-up evaluation.

It is not difficult to challenge this study on several grounds. One might justifiably question the absence of clinical-behavioral criteria, particularly the logical "payoff"—discharge rates. There is the possibility of some confounding of results as a function of higher patient drop-out rates in the student groups. Furthermore, there is a systematic bias in therapist sex in that all lay therapists were females, whereas most professional therapists were males. Even so, one is hard-pressed to explain why patients seen by lay therapists should have improved significantly *more* than those seen by professionals. The data oblige us to look at other than intellective, training, and experiential variables as the viable factors underlying improvement in this situation. Both Poser (1966) and Rioch (1966) hypothesize that the critical change agent may well have been the interest, enthusiasm, and energy which the students brought to the situation. Variables of this type do not belong exclusively to the professional; indeed, there are many circumstances under which we might more readily expect to find them in the nonprofessional.

The findings of the Poser investigation, in addition to highlighting the potential of the nonprofessional as a mental health worker, provide considerable food for thought. The study is clearly paradigmatic rather than definitive. It is limited by the particular conditions of the research—i.e., a mental hospital setting, chronic schizophrenic patients, a group therapy approach, and a particular criterion test battery. Poser recognizes these limitations but, within the framework established by them, concludes: "the present findings . . . support the conclusion that traditional training in the mental health professions may be neither optimal nor even necessary for the promotion of therapeutic behavior change in mental hospital patients" (1966, p. 289). The results of this striking study support the contention that we should explore further the utility and the potential of the nonprofessional in mental health settings.

ROLES AND FUNCTIONS

When attention is turned to questions of the roles and functions of the nonprofessional, the determining quality of our guiding conceptualizations is underscored. How nonprofessionals (or, for that matter, professionals) are utilized rests largely on the model we hold, the goals and aims we see as primary, and the programs we devise to implement these objectives.

These principles can best be illustrated in the context of our earlier discussion of conceptual models. For example, if helping programs are built in the image of the medical model as we have defined it, then what is called for is a type of taxonomy of job components with categorization of some elements as higher-order and some as lower-order. In this case, higher-order would refer to functions which, presumably, could only be performed by the professional; lower-order would refer to those which could be handled by a nonprofessional. Relevant to this point Reiff (Ch. 5) draws an analogy to the industrial model in which we seek to ". . . break up complex highly skilled operations into a series of more simple tasks. The simplification of production processes reduces the amount of training necessary and this makes increases in the manpower pool feasible" (p. 80).

This approach does not challenge the assumptions of the guiding model; instead, it is addressed to meeting what is seen as a central shortcoming of the model—a lack of "manpower muscle"! For example, clinical psychologists tend to define psychometric functions as among the least interesting and least demanding of their professional activities. Accordingly, there is considerable interest in training people at the M.A. level to function as psychometrists. The presumed consequence of this would be to free the Ph.D. psychologist to engage in activities requiring higher-level skills. The delegation of these "expendable" skills is proposed as an aid toward a more efficient total operation within the presently defined framework and as the basis for achieving an arithmetic increment in its scope. However, the need to free the time of the highly trained professionals may prove to be a less important matter than the issue of how that time is utilized.

Earlier we noted a general inclination to divide professional activities into higher-order and lower-order ones and to relegate the nonprofessional to the latter functions. This bias, though recognizable in many programs designed for the nonprofessional to date, is not mandatory. Indeed, the very designation of what is or is not a high-level professional function is, in itself, a value judgment. Rioch (Ch. 7), for example, selected an activity from among the most highly prized functions of the professional—i.e., the conduct of psychotherapy—and successfully trained middle-aged housewives to do this work. Within the framework of the medical model, there are nearly as many potential roles and functions for the nonprofessional as there are separate professional activities which can currently be identified. Particularly in the light of findings of people such as Poser (1966) and Rioch, Elkes, Flint, Usdansky, Newman, & Silber (1963), it would be unwise to assume that there is *any* type of interpersonally-based help for troubled individuals which can only be rendered effectively, or best be rendered, by the mental health professional.

The nonprofessional in the mental health field has been used preponderantly within the classic framework of the medical model in a variety of direct service activities with emotionally disturbed individuals. Several illustrations of such functions appear in the present volume, for example: as social or milieu therapists in a state hospital setting (Sanders, Ch. 8), as psychotherapists (Rioch, Ch. 7), and as companions to mental hospital patients (Holzberg, et al., Ch. 6), as well as in the literature (e.g., Greenblatt & Kantor, 1961; Greenblatt, 1962; Holzberg, 1962; Kantor, 1962; Umbarger, Dalsimer, Morrison, & Breggin, 1962; Holzberg & Knapp, 1965; Klein & Zax, 1965). Though most of these examples involve college students working with adult mental hospital patients, other usages have also been reported—for example, as case-aides in mental hospital work with children (Reinherz, 1963a, 1963b), as big brothers for troubled children in rural settings (Mitchell, 1964, 1966), and as staff in a halfway house (Huessy, 1966b). Indeed, several recent reports have described the use of high school students as mental health aides. Fellows and Wolpin (1966) report a project in which they served effectively as group leaders, counselors, tutors, and operant conditioners on a state hospital ward for adolescents and preadolescents. Similarly, Cytryn and Uihlein (1965) found that high school students, functioning in instructional and recreational capacities with young mental defectives, were capable of making important contributions to the development of these youngsters.

Nonprofessionals have also performed mental health functions in situations other than standard clinical settings, in situations aimed at individuals who would not, under ordinary circumstances, have been objects of concern for the helping professions. Many of these functions can be seen as integral to programs emphasizing early secondary prevention. Examples of these latter roles are represented in the present volume—counselors in a pregnancy or well-baby clinic as described in Rioch's second program (Ch. 7), the "teacher-mom" who works intensively with the seriously disturbed child (Donahue, Ch. 20), the teacher-therapist who is friend, companion, parent-surrogate, teacher, and helper to disturbed youngsters on a round-the-clock basis (Lewis, Ch. 19), the mental health aide and day-care activity leader in the school (Zax & Cowen, Ch. 18)—and elsewhere in the literature (Hereford, 1963; Donahue & Nichtern, 1965; Rockefeller, 1965; Cowen, Zax, & Laird, 1966b; Huessy, 1966c; Zax, Cowen, Izzo, Madonia, Merenda, & Trost, 1966).

Still other roles and functioning will be found for the nonprofessional in mental health programs outside the orbit of the medical model—those which are preventively oriented, directed to community action and social system modification. Since this type of program tends to be newer and less well articulated than traditional services, it follows that it is more difficult to define the place of the nonprofessional within the program. The problem in this instance is not one of breaking down complex, old, and clearly specifiable functions into simpler and more manageable subunits; rather it is one of carving out new, seemingly "foreign," and "difficult to conceive" functions from scratch. The very definition of what *is* a mental health problem is a central issue here and, with it, what actions may be encompassed under the banner of mental health operations. As an example of the latter, it is interesting to note some recent promising departures from traditional modes of rendering helping services to the poor, such as treatment in the home (Levine, 1964) and role playing (Riessman & Goldfarb, 1964).

If we bear in mind, as Reiff (Ch. 5) has emphasized, that improvement of the mental health status of the poor is dependent on social systems modification and community action, and that problems of self-determination and coping skills far outweigh those of psychodynamics or self-actualization for this group, then an alternative set of highly viable mental health functions for the indigenous nonprofessional can be specified. In the main, these functions, some of which have been described by Reiff and Riessman (1965), by Brager (1964) in connection with the Mobilization for Youth project, and by the Howard University group (Fishman, Klein, MacLennan, Mitchell, Pearl, & Walker, 1965; MacLennan, Klein, Pearl, & Fishman, 1966), are directed toward resolution of the highly concrete, mundane, everyday problems of the poor. Some of these new roles, particularly in the context of community action programs, are as follows: *housing service aide*—to provide information about available housing and to organize neighborhood improvement; *homemaker*—to help families become more competent in home management, offer companionship or psychological support, furnish information on community facilities, actually take people to agencies or community meetings, or provide babysitting services to make this possible; *community action aide*

—to establish close relations between the community action agency and community institutions and organizations (such as area schools, churches, and civil rights groups); *expediter*—to bring together a person needing service and the agency that provides it. In addition to these community action roles for the nonprofessional, Reiff and Riessman (1965) and the Howard group (Fishman et al., 1965; MacLennan et al., 1966; Klein, Ch. 9) have described a number of human service or community mental health roles for the poor such as home service aides, child service or child care aides, casework aides, recreational aides, and research aides.

Despite the variety of roles and functions for the nonprofessional which have already been explored, the surface of this area has scarcely been scratched. This is a period of considerable ferment and exploration, triggered by a recognition, independent of the model we hold, of the vast potential of this resource. In the near future we are likely to witness increased efforts to scrutinize and evaluate the impact of already identified roles, as well as an intensification of our search for meaningful, contributory, new mental health-relevant functions for the nonprofessional.

SELECTION, TRAINING, AND SUPERVISION

We shall probably find that the range of human beings who can be used effectively to perform significant functions in the mental health enterprise is extraordinarily broad. This likelihood is reflected even within the relatively limited confines of the present volume where programs utilizing college students (Holzberg et al., Ch. 6; Zax & Cowen, Ch. 18), college graduates (Sanders, Ch. 8), teachers (Lewis, Ch. 19), and highly educated housewives (Rioch, Ch. 7), are described. Each of the foregoing categories of nonprofessionals is more fully represented in the literature—some (e.g., college students and indigenous nonprofessionals) rather extensively. In addition, other, more specialized groups have been utilized as nonprofessional helpers in a variety of recent experimental or pilot projects. Examples of these groups include delinquents (Hubbard, 1963; Slack, 1963; Schwitzgebel, 1964), criminals (Briggs, 1963; Hawkinshire, 1963; Oberhauser, 1963), children, and retired oldsters. These explorations of new sources of manpower reflect a perceived need and a growing awareness of the special potential of the nonprofessional. The diversity of recruits in existing programs spans basic dimensions of human individual differences, such as age, sex, education, socioeconomic level, and social status. However, we still have minimal knowledge of what these people can do, who is likely to be most effective in what setting, etc.

Tactics and stratagems for recruitment of the nonprofessional worker have been marked by their variability. In some instances, the prime recruitment attribute is self-defining. For example, the indigenous nonprofessional must indeed be indigenous (Reiff & Riessman, 1965). If the change agent is a current or former member of a target group (e.g., ex-delinquent with delinquents, ex-addict with addicts, ex-criminal with criminals)—a factor which is central to many programs (Calif. Dept. of Corrections, 1963)—that criterion is the prime (but not, necessarily, the only) element in selection.

Many programs, particularly those involving college students, have been largely self-selecting or at least self-screening (e.g., Umbarger et al., 1962; Holzberg et al., Ch. 6). Others have involved only gross negative screening (e.g., Zax & Cowen, Ch. 18, for college students) to rule out the few who may be either seriously disturbed or grossly unsuited. Still other programs have specifically selected workers, generally using individual or group screening techniques (e.g. Rioch, Ch. 7; Sanders, Ch. 8) on the basis of a set of positive criteria thought to be relevant predictors of subsequent performance. For example, Reiff and Riessman (1965) speak of desirable attributes of the indigenous nonprofessional other than his neighborhood roots. These include a concern about neighborhood problems, an interest in and ability to work comfortably with others, a willingness to communicate across class lines, and a capacity to learn and to develop. Zax and Cowen (Ch. 18), in selecting housewives for roles as mental health aides in the classroom, placed considerable emphasis on attributes of personal warmth, a relatively successful child-rearing history, an interest in working with young children, and a non-crusader orientation toward the school—a selection pattern similar to that utilized by Rioch (Ch. 7).

It should be recognized that when such selection criteria are specified, they largely reflect best guesses for a given situation. At this time we have very little empirical evidence as to what attributes in the worker relate to what outcomes in the recipient. Establishment of positive selection criteria for nonprofessionals is often associated with programs that have heavy training or supervisory investments, the feeling being that if so much effort is to be put into the program, it is best to respect those hunches which could maximize the possibility of hoped-for outcomes. Failure to adopt selection criteria or use of minimal criteria mirrors greater acceptance of our present limited understanding of "who-can-help-whom" contingencies and, consequently, a more open approach to their resolution.

Training of the nonprofessional is directly related to the basic model we hold, as well as to the prospective roles and functions of the worker (Riessman, Ch. 10). Two principal issues reflected here are, first, the question should there be training, and, second, if there is, what should its form and content be? For example, if we see the nonprofessional as someone who should be taught to take over specific components of the professional's activities, then a period of concrete background and skill training directed toward achievement of mastery of those functions is clearly indicated. The length of that period will vary with the group being trained, the skills to be imparted, and the amount of background context considered relevant. In practice, such training has run the gamut from a relatively brief, circumscribed course of five or six weeks (e.g., Zax & Cowen, Ch. 18) through a more extensive and rounded one-year program to prepare social therapists (Sanders, Ch. 8), to nearly two years of full-time study including theoretical, didactic, and practicum components, as in the case of the preparation of Rioch's (Ch. 7) initial housewife group for careers as psychotherapists. In this regard, one note of caution should be sounded. To the extent that training programs for nonprofessionals require several years or more of intensive training, they are likely to be professional training programs in disguise, minus the usual terminal degree. In any large-scale social sense, it will not be possible to maintain such programs for the very same reasons that limit our potential for training the full-fledged mental health professional.

If, as many have come to feel, personal and motivational qualities are more important than specific skills as active ingredients in the helping process, then less importance will be attached to the need for training. In this latter instance, training may be used more to activate systematized and searching reflection about relevant people or situations and to help build confidence and security under relatively nonthreatening circumstances than to impart a specific body of knowledge. From this viewpoint, the selected nonprofessionals are assumed to be individuals who, by personality, life experience, or whatever, have a good deal to offer others; it would be unwise to tamper excessively with their styles and natural reflexes by teaching them the "right" way to do things.

Once a decision about the need for training has been made, a number of procedural questions pertaining to both content and form must be engaged. Though content is often determined by the functions for which the worker is prepared, the rule is not always so simple. In some instances we may wish to prepare the individual for a variety of functions, or we may find that substance cannot really be engaged before a change in values and attitudes has been effected. Klein (Ch. 9) utilizes the personally-oriented "core-group" approach to bring about such change. The purpose of this group is to enable the trainee to learn "more about himself, the community, and the world he lives in" and how his job performance is related to "his personal life, aspirations, and relationships with other trainees" (Ch. 9, p. 150).

Likewise, the form of training programs may vary considerably. In this regard, one obvious and highly salient dimension is level of abstractness or concreteness. There are largely didactic approaches, those featuring a discussion orientation, and those that largely emphasize experiential components; and within each of those gross categories, there are many exemplars. As with length of training, both the form and content of training programs must be determined by the attributes of the group being trained and by their contemplated roles. What is appropriate for the college student who will work with schizophrenics in a state hospital does not make sense at all for a hard-core delinquent from a slum neighborhood who will be working as a child care aide. The characteristic training needs and styles of a given group, rather than our own rigid preconceptions and preferred ways of imparting knowledge, should shape the training program. With some groups, particularly among the poor, it may be, as some have suggested (Reiff & Riessman, 1965; Klein, Ch. 9), that a "job-first, training-next" approach is the only feasible one.

Experience with specific training situations puts one in a better position to establish more informative guidelines for such training. Reiff and Riessman (1965), for example, have identified certain principles which they believe are basic to the training of the indigenous nonprofessional. These include "continuous on-the-job training" starting from the very beginning, building from simple to more complex functions, emphasizing activity rather than a lecture approach (i.e., doing in preference to talking), building group solidarity, provision of "informal individual supervision at any time," "a down-to-earth teaching style," and helping workers to become aware of their personal styles and to feel free to utilize them. This particular recipe is born of experience. We shall need others suited to other groups and situations.

One of the very real problems facing the would-be trainer of nonprofessionals is that we are unsure of the training "whats" and "hows." Curricula are unavailable and usually have to be developed from scratch for a particular situation; to a considerable extent, our forms of approach are "trial balloons." We have neither proven training methods nor experienced and knowledgeable trainers, and one of our striking needs is that of training people for training—"metatraining." It is therefore necessary that a fair amount of the professional's time be devoted to training, resource, and supervisory functions. Such supervision carries with it the potential for education, support, and personal growth of the worker. In many instances, these ends may be furthered by group supervisory techniques unless these are alien or inimical to the life style of the trainees.

SPECIAL ASSETS OF THE NONPROFESSIONAL

Quite apart from the standpoint of social need, it is entirely possible that the nonprofessional belongs in mental health activities because of special, and sometimes unique, contributions that he can make. More boldly stated, there may be helpful things that the nonprofessional offers or can do which simply cannot be duplicated by the professional.

One illustration of this point was seen in the discussion of Poser's (1966) untrained college students, who were found to have more impressive "batting averages" than trained professional specialists in group therapy work with chronic schizophrenics. In seeking to explain these surprising findings, both Poser (1966) and Rioch (1966) hypothesized that the critical factor underlying the observed differences in patient groups may have been the energy, enthusiasm, and involvement of the nonprofessional. These qualities have been noted in many reports of programs utilizing nonprofessionals (Umbarger et al., 1962; Holzberg, 1963; Klein & Zax, 1965; Cowen, et al. 1966b). It is reasonable to suppose that if a helper is interested and enthusiastic, he communicates those feelings to the recipient. Such an ingredient may be an important determinant of constructive change. Some critics, even though they recognize this point, have gone on to "look the gift horse in the mouth." Thus, Rosenbaum (1966), commenting on the Poser findings, states: "Certainly, people who have been rejected by the culture will respond to young, vibrant people who are humane and extend warmth. But here we are speaking of compassion and humaneness. Is this to be equated with the process of psychotherapy?" (p. 294). Given the known difficulties of effectuating positive change in human behavior by any means, to insist that change is true change only when it follows psychotherapy, or interventions by trained professionals, is a luxury we can ill-afford!

The more cogent concern about the "involvement-enthusiasm" hypothesis is whether these characteristics are basic distinguishing attributes of the nonprofessional, or whether they are characteristics of most human beings as they become involved in exciting or challenging new experiences for the first time. Rioch (1966) raises precisely this issue when she suggests that the success rates of the nonprofessional might well taper off if they repeated the same activities over a five-year period. Such an hypothesis is both tenable and testable. If confirmed, it might point to constructive modification of programs for the mental health worker to include continuing exposure to new activities and experiences. In this way involvement and interest could be maximized, and the benefits to be derived from human enthusiasm could be more effectively harnessed. We may note, in passing, that the same argument can also be applied to the professional who, performing repetitive activities under conditions of limited positive reinforcement, may eventually burn out.

Another possible advantage of the nonprofessional has been pointed out by Rioch (1966). She observes that such individuals may bring "fresh points of view, flexible attitudes and sometimes new methods into the field" (p. 291). The nonprofessional is not bogged down by the absolute knowledge and illusion of certainty which often encumbers the professional. In his naïveté he may be more likely to stumble on effective and pragmatic new ways of approaching problems which the professional would have rejected as unsophisticated, improbable, or foolish. Thus, the open-minded professional may actually be in a position to learn and profit from his associations with nonprofessionals.

A special element of the flexibility argument is that the nonprofessional can do things that the professional, by virtue of breeding and role-prescriptions, ordinarily cannot or will not do. He is in a position to be less formal and less rigid (Huessy, 1966b). Limits on his participation are less clearly prescribed. As Reiff and Riessman (1965) observe, "he can be invited to weddings, parties, funerals, and other gatherings—and he can go" (p. 7).

The importance of this potential should not be underestimated, particularly so as we place increasing emphasis, in our mental health models, on the value of concrete, everyday, coping experiences in contrast to intrapsychic determinants. While the nonprofessional's freedom of action will undoubtedly vary as a function of particular circumstances, with some groups, especially the poor, it may be a factor of considerable potential. He is in a position to cut through certain types of role-distance problems inherent in many existing, middle-class-based, helping procedures where technique is inconsistent with the life style or expectancies of the poor (Riessman, 1965).

There is another, not entirely unrelated, point to be made. Rioch (1966), in her discussion of Poser's findings, has suggested that one possible explanation for the relative success of the nonprofessionals was "that the patients cooperated more readily with people who were felt to be closer to themselves in the social hierarchy, that is close to the bottom of the ladder" (p. 292). This principle is the central element in a variety of helping approaches, for example, "AA," Recovery Incorporated, or Synanon (Yablonsky & Dederich, 1963; Volkman & Cressey, 1964), where efforts are made to reduce social distance factors to zero by using a former victim of a condition as the helping agent for current victims.

But, the argument is not limited to such specific instances. In the broader sense, we are speaking to the variable phenomenology of people who need help. Among them there are undoubtedly some who perceive the professional as an unapproachable authority, as someone who is removed from their problems, or as a person with whom they cannot communicate because he is what he is. For such individuals, and they need not be lower-income people, these perceptions may block the possibility of being helped. There are, of course, many others for whom the authoritative and status-related attributes of the professional may be a helpful or facilitating element. Thus, the key to being helped will be found, for some individuals, in an authority relationship; for others, in a peer relationship. It is more than admissable that the nonprofessional will have advantages over the professional in establishing the latter.

So far, we have attempted to identify in a general way some of the potential special assets of the nonprofessional. In particular circumstances these assets may assume even greater importance; and other attributes, not yet identified, may take on significance. Illustratively, Reiff and Riessman (1965) emphasize the social distance factor as one of the truly critical advantages of the indigenous nonprofessional. He, like the people he serves, is poor. He shares a common background with them, comes from the same neighborhood, and has suffered similar agonies. These factors facilitate his acceptability from the consumer's standpoint and, at the same time, make it easier for him to identify and to establish rapport with them. "Know-how" is another attribute of the indigenous worker. He is thoroughly familiar with the neighborhood, its heartaches and difficulties, and ways of dealing with problems in such settings, far more so than is true of almost any professional. This puts him in a good position to perceive individual needs in their natural context and to undertake sensible and appropriate actions that will be seen as such. Finally, Reiff and Riessman (1965) identify the special contributions coming from the "style-match" between the indigenous nonprofessional and his clientele. His natural way of doing things is also their natural way. It is readily understood and comfortably accepted. Some of the characteristics of the indigenous worker's stylistic preference for approaching life's problems which are both salient and highly adaptive to his functions and his setting are the following: practicality, an external view of the causes of human difficulty, a concrete action-directed posture, and a militant stance with respect to authority and social action.

CHANGES IN THE WORKER

Through experience gained with a variety of programs, there is growing reason to believe that one potentially significant consequence of genuine involvement of the nonprofessional in mental health functions is constructive personal change in himself. Such change may occur at different levels depending on the specifics of groups and programs, and a modest amount of objective evidence can be cited in support of the basic proposition. For example, Holzberg et al. (Ch. 6) and Cowen et al. (1966b) report positive change in the attitudes of college students following their participation in helping programs for mental hospital patients and public school children, respectively. Klein and Zax (1965) indicate further that such an experience may increase the likelihood of college students going on to future mental health careers. And at a very different level it has been shown (Klein, Ch. 9; Riessman, Ch. 10) that former delinquents, high school dropouts, and welfare cases may, through participation in mental health-related functions, go on to careers in the human service fields.

For many nonprofessionals, the process of being genuinely helpful to another human being may have considerable personal value. Riessman (1965) has referred to this as the "helper"-therapy principle. Rioch (Ch. 7) has spoken of this in terms of bringing together multiple social problems in their resolution. It is a principle which, at least implicitly, has been recognized for many years and, indeed, lies at the root of venerable programs such as "AA" or Recovery Inc. Riessman carries this point one step further by suggesting that the principal values of such programs may well be for the helper, rather than for the target person.

There are many people who, by virtue of their life experience or the very structure of society itself, are put in a position of being able to do little more than exist. Their lives are characterized by a void, a lack of fulfillment, and no clear sense of direction or purpose for the future. Rioch (Ch. 7) observes that this is the fate of many middle-aged housewives whose children have grown up and left the home. For very different reasons, the same end-result may typify large numbers of low-income people and groups as diverse as delinquents, offenders, and retired oldsters. Such people can be viewed as an important potential resource in the mental health field, since, through the act of helping others, they may also be able to help themselves. Because, in some instances, these represent limited prognosis groups, the latter potential is not to be overlooked. There is need to plan for more systematic utilization of nonprofessionals who may need the opportunity to be genuinely helpful to others and can grow from such activity.

A variety of mechanisms have been hypothesized (Reiff & Riessman, 1965; Riessman, 1965) to account for the positive personal changes which some nonprofessionals have undergone through their human service experiences. There is the value of having a stake in, and a responsibility for, a meaningful job, including the satisfaction derived from acquiring new skills. That these skills can actually help someone who needs help may serve to bolster one's self-image either directly through the demonstration of concrete achievement or indirectly through the cognition that to help others one must, himself, be in reasonably good shape. There may also be straightforward benefits accruing to some because of an increase in status and prestige derived from their new role. Finally, the need for the helper to be able to impart knowledge may force growth by putting him in a mandatory learning position. These mechanisms may be thought of as helpful either individually or interactively and will certainly operate differentially in individual cases.

The help that the nonprofessional mental health worker, particularly the more vulnerable one, derives through helping others contributes directly to the resolution of one set of social problems, creating more effective workers, and thereby establishes a potent force for the resolution of other social problems. There is an intrinsic appeal in the pyramidal or multiplicative potential of the approach, which is opposite in its structure to the better known and oppressive vicious circles that have plagued mental health specialists for so long.

POTENTIAL PROBLEMS

Despite a growing willingness, sometimes born of desperation, to examine what the nonprofessional may be able to offer in various mental health programs, judgments about his contributions have largely been impressionistic. Since such personnel have not been used systematically for very long, we have not really had a chance to learn what the nonprofessional can or cannot do or to identify essential parameters that relate to effective functioning in various roles and settings. Accretion of such information is a vital prerequisite for building a more efficient and effective mental health order. To acquire this information will require openness, an inquiring spirit, and a willingness to explore freely in new directions. The guidelines of overinclusiveness and respect for the good hunch are to be preferred to those of constriction and preconception. The danger of such a course is that it virtually guarantees that mistakes will be made. Hopefully, however, these will be mistakes from which we can profit!

Even the strongest advocates of nonprofessionalism (e.g. Riessman, 1965) have been careful to cite some specific potential pitfalls, such as projection of one's own difficulties by the unsophisticated worker or the communication of the worker's problems to problem-free individuals with whom he may come in contact. Additional concerns of this type, specific to the indigenous nonprofessional, are discussed by Reiff and Riessman (1965). Difficulties will undoubtedly arise, but the hope is that the strengths and resources that the nonprofessional has to offer will outweigh the inevitable debits. The development of nonprofessional manpower resources does not imply an abdication of professional responsibility. Rather, it calls for a redefinition of such responsibility, some of which will take the form of monitoring and supervising the nonprofessional. This may provide a part-vehicle for minimization of the types of potential difficulties alluded to above.

Ironically, one of the major problems facing the nonprofessional movement lies in the stance of many mental health professionals, who perceive in it the danger of encroachment on their terrain (Sanders, Ch. 8). Whether the threatened needs are rooted in economics, prestige, or status is not particularly germane. The fact of resistance in professionals, who represent strongly vested interests and often operate from positions of considerable power and influence, could prove to be a significant deterrent to this type of development. As has been the case in prior interprofessional jurisdiction disputes, such matters are not easily approached on a rational basis. Rioch (1966) highlights this issue succinctly in the course of her comments on the Poser study. "If we have invested long years of hard work in achieving a high professional status, including many courses that were dull and many examinations that were nerve-wracking, and we are told that some bit of a girl with no training can do the job just as well or better than we can, it is natural that we should try to find some objections" (p. 291).

Verbalization of concern by the professional about utilization of nonprofessionals as helping people clusters around arguments such as their presumed lack of understanding and qualification and, particularly, the danger that they may do irreparable harm to another person (Bellak, 1964b). Even if this concern were founded, and there is no basis for assuming that it is, the argument overlooks the fact that still greater harm is being done every day by our inability to offer any help to individuals who need it. The mental health movement has probably suffered more from its errors of omission than from its errors of commission, and we would be well advised to begin to correct some of the former, even at risk of the latter. Conceivably, in the course of so doing we might have the opportunity to reevaluate our present fairly rigid definitions of what is "error" in the mental health field.

The foregoing discussion notwithstanding, it would be indefensible to argue that only personal reasons prompt professionals to object to the use of nonprofessionals in mental health programs. Emphasis has been placed on these types of reactions because they are identifiable, strong, and dangerous ones. But it is clear that reservations can be formulated on solid intellectual grounds and in perfectly good faith. Indeed, earlier in this discussion, it was noted that even ardent advocates of the use of nonprofessionals are somewhat skeptical about the approach and have spoken to some of its danger points. Reiff (Ch. 5), for example, speaks of the dangers of power struggles which may develop between the professional and the nonprofessional and of the tensions around such struggles.

Finally, there are certain practical problems, albeit thorny ones, that should be noted. One of these pertains to the level of specificity at which the nonprofessional should be trained (Sanders, Ch. 8). In highly oversimplified form, two orientations to training can be identified—one which emphasizes the agency needs that have to be met and the other, the development of the trainee. Since many early training programs have developed in specific institutions, clinics, or agencies, there has been an understandable inclination to orient training rather specifically to the needs of the setting. Trainee-centered programs, while they recognize the necessity of providing skills and "know-how" suited to work in a particular setting, seek to go beyond such specificity. They assume that there are certain values, attitudes, and work habits which, for some groups, must be achieved as a prerequisite to effective function in almost any type of human service work. Further, justification for such an emphasis comes from the difficulty of knowing beforehand where a trainee will be placed and whether he will remain there. For these reasons, a more flexible type of preparation is to be preferred. Klein (Ch. 9) exemplifies this latter approach and utilizes the "core group" situation, plus on-going exposure to varied types of job activities during the training period, as the mechanisms for achieving the desired leeway.

In some instances arrangements can be made beforehand to absorb the nonprofessional in a "captive" agency where he is being trained. In other circumstances, however, especially where new roles and functions are being carved out and where training is conducted by an organization which is largely performing a service function (e.g., a University or a Community Mental Health Center), issues attached to the absorption of workers by community agencies can become both complex and central. Job functions for which people are to be trained have to be conceived in the light of their potential utility in certain settings. Even if responsible administration in these settings, as an abstract principle, accepts the fact that a nonprofessional could be useful, practical problems may be expected—such as the lack of available budget or the absence of the proper spots in the agencies' table of organization. These realities point to the absolute necessity of the professional's working closely with representatives of potential recipient agencies from the very beginning. They point also to the need for close on-going liaison between trainers and recipient institutions. Unless these mundane problems can be resolved, the best of training may have been for naught; in their resolution, some strikingly new roles for the mental health professional will be required.

After the worker has been placed, other difficulties may be anticipated. One of the most important of these is the resistance, in word and deed, which may be thrown up by vested interest employees of the recipient agency, who may perceive in the nonprofessional the time-honored spectres of encroachment and threat. Another problem, noted previously by Reiff (Ch. 5) and Klein (Ch. 9), is the striving for upward mobility and further education which some nonprofessionals have. This type of reaction may be a perfectly natural consequence of early satisfaction and success and, with it, a growing recognition of one's potential. It is to be hoped that there will be sufficient flexibility in our systems so that such needs may be respected and accommodated.

In conclusion it is a matter of underscoring the obvious to point out that there are relatively few professionals who have the know-how, the experience, and the interest required for training nonprofessionals. Our system will not expand in needed increments if these people are usurped in trying to meet circumscribed and repetitive service needs. A prime necessity is that they be utilized for the training of trainers, so that the promise of multiplicative expansion may be furthered. Beyond that, the time of the qualified professional trainer may best be used in the establishment of training models, in the evaluation of their effectiveness, and in working toward absorption of the product in appropriate community agencies. Insofar as possible, a concerted effort should be made to help the agency to increase its participation and ultimately to assume responsibility for training. This implies a gradual shift in the role of the professional, vis-à-vis a given training program, from one of leadership to one of consultation. As this is achieved, he will be free to work toward the development and evaluation of new models.

THE MENTAL HEALTH PROFESSIONAL

Change in our approaches to mental health problems and redefinition of the scope of the helping professions demand that careful consideration be given to the changing role of the professional specialist. Indeed, several recent conferences have been devoted to this theme (Hoch & Raush, 1964; Goldston, 1965a; Bennett, Anderson, Cooper, Hassol, Klein, & Rosenblum, 1966; Hoch, Ross & Winder, 1966). There is little basis for suggesting that all of the substance of present training for mental health professionals be dropped. To the contrary, the point has been made (Bernard, 1964; Berlin, 1965) that at least some of what we now train for—knowledge of personality development, self-awareness, an abiding concern for the individual—is not only useful but necessary for effective functioning in emergent roles. It will be some time before we can pinpoint with confidence those aspects of current training that are viable and those that are not. Given the shifts in orientation already proposed in this chapter, however, certain recommendations about utilization of the mental health professional follow almost automatically. Some of these, at least in fragmentary form, have appeared in our discussion of earlier issues. The aim of the present section is to achieve a more coherent and systematized presentation of these views.

The critical problem in this area is optimal utilization. A basic redistribution of our limited professional resources is needed so that they become more potent forces in efforts to reduce the mental health problems of modern society. The most important determinants of any such reapportionment will be found in the conceptual models that we hold.

As one basic focus, we require a shift in the balance of the professional's activities so that a relatively greater proportion of his time becomes system- or institution-directed and a relatively smaller portion is individual-centered. Given limited total resources, we must reduce currently favored one-to-one clinical functions such as psychodiagnostics and psychotherapy and judiciously allocate those one-to-one services that remain. It is also necessary for the professional to exchange portions of his historically preferred passive stance for a more active problem-seeking orientation. This means replacing a significant amount of office, clinic, and hospital time with mental health-relevant activities in the community and its primary institutions (Felix, 1962; Caplan, 1965b). It does not mean a simple transfer of the same technology from one set of buildings to another. The attractiveness of the community resides in the opportunities it offers for constructive modification of influence systems, more sensible timing of intervention, extension of the scope and effectiveness of our helping operations, and stemming the flow of disorder. Granted that these are diverse ends which are to be achieved in very different ways, they are also very basic and historically neglected ends. Unless a substantial portion of our total professional resources can be funneled in these directions, we shall find ourselves struggling eternally to tread water (Hobbs, 1964).

More concretely, the professional can extend his contributions markedly through consultation with impactful care-givers (and other people in society who influence mental health status because they inevitably have contact with individuals in crisis situations), as well as with key community agencies and institutions. The full potential of the latter of these two approaches will be more nearly achieved to the extent that constructive modification of systems, rather than simply individual or case review, becomes a focus of consultation.

If, as we have assumed, professional resources will be insufficient to meet mental health needs and a part resolution to this problem lies in the judicious use of nonprofessionals, then it follows that a greater portion of the professional's activities will be devoted to work with such individuals (Duhl, 1965). He will need to be concerned with the nonprofessional in many ways including: definition of roles and functions in conjunction with appropriate community agencies; recruitment and selection; development of a variety of training curricula; conduct of training; and initial placement as well as continuity of function. Under some circumstances, effective execution of these functions may bring the professional into community action and quasi-political roles, since program implementation cannot always be divorced from the social context in which it is to take place. In the aggregate, however, the basic shift in professional roles which is called for lies in the substantial replacement of clinical service with educational, supervisory, consultative, and resource activities.

If we may compartmentalize functions of the mental health specialist, we are speaking of a movement by the professional away from the traditional clinical-practitioner mold toward two relatively new and evolving ones—those of the mental health "quarterback" and the "social engineer." There are no special difficulties attached to envisioning and operationalizing these two new molds (indeed, for the first we have done so already), but there are some very fundamental issues that must be raised about the qualifications of the mental health specialist for the role of social engineer. The essence of this role involves the analysis and understanding of social systems, their relation to human development, and ultimately, how their modification may constructively affect such development. When we try to point to the specific skills that will be needed to meet such objectives, as has been done at a recent training conference (Bennett et al., 1966), areas such as the following receive prime designation: group action, epidemiology, community organization, public administration, evolution and change strategies in social systems, principles of ecology, biostatics, etc. Given the underlying objectives, one can readily see the relevance of each of these areas to the task; yet few, if any, are even approximated in presently existing curricula for the advanced graduate training of the mental health professional. The social psychologist would come somewhat closer to such training than the clinical psychologist, and perhaps the sociologist would come closer than either.

Sarason et al. (1966) use the term *preciousness* to describe the tendency of mental health professionals "to view what they are and do as unique, and to believe that they are the only ones to 'truly' understand, grapple with and effect changes in individuals beset with problems in living and adjustment" (p. 34). It would be an act of extraordinary preciousness for any one or all of the helping professions combined to assume that they had special calling or unique qualifications for social engineer functions. To be sure, the helping professions have a vital stake in the furtherance of this role, and unquestionably, they can contribute much both by helping to frame meaningful questions and by contributing to their resolution. But it is not for the helping professions to go it alone. They do not have the skills to do so. Again quoting Sarason et al. (1966), "To study and understand the community with the intent of serving it will require a type of personnel that now does not exist" (p. 648). Indeed, we may question whether there will ever be a single profession with the requisite skills for such a broad and demanding task. When mental health problems are approached at the level of the basic fabric from which society is fashioned, then appropriate modifications of the training of the professional can help him to understand relevant issues and determinants more fully, propose more cogent questions for study, widen his repertoire for answering these questions, and work more effectively with other groups toward achieving shared objectives. All this, however, will not alter the fact that the intrinsic complexity and depth of roots of mental health problems are such that we shall always require significant, continuing involvement of other groups working toward the furtherance of their resolution.

More specific discussion of issues of professional training in this area raises a series of troublesome questions. (Based on a survey of chairmen of departments of psychiatry, one source has recently categorized well over one hundred such questions [Goldston, 1965b].) On logical grounds, the most basic of these is what is really meant by the term *this area?* Most existing training programs utilize the word *community* somewhere in their descriptive titles (e.g., community psychology, community psychiatry, or community mental health). But, as we have suggested earlier, this is a highly amorphous term which defines neither the conceptual model guiding the training nor its logical derivatives–i.e., the scope and content of the activities for which the professional is being prepared. Accordingly, two programs–each labeled as a training program in community mental health–need not have similar content at all. As an illustration, a program set up in the image of the mental health "quarterback" might place much heavier emphasis on care-giver and agency consultation, crisis intervention, and supervision of nonprofessionals than would one which is in the "social engineer" tradition. The latter, impinging as it does on methodologies and skills drawn from diverse areas, should have a much stronger cross-disciplinary flavor.

Structural variations are also found in professional training programs, and these exist at several levels—intradisciplinary versus cross-disciplinary and postdoctoral versus predoctoral. One of the earliest programs to be developed was that of Caplan (1959b), designed to provide one to three years of training essentially for experienced postdoctoral specialists from various of the helping professions (i.e., psychiatrists, psychologists with the Ph.D. plus some experience, and senior social workers). The first year of this program, leading either to an M.A. in Public Health or an M.S. in Hygiene, is largely didactic and cross-disciplinary in nature, including work in biostatistics, ecology, community organization, and epidemiology, among other areas. Later years are devoted primarily to practicum training in affiliated field stations. More recent modifications of this program are described elsewhere (Baler, 1965).

Other types of postdoctoral training in community work exist, sometimes less well articulated or specialized than Caplan's program. Such training may be intradepartmental or interdisciplinary and is most often available in a medical setting. There has been a highly noticeable trend, for example, to provide for rotation through one or more community-relevant activities as part of many residency and postresidency training programs in psychiatry (Bernard, 1964, 1965; Hume, 1964; Daniels & Margolis, 1965; Goldston, 1965a, 1965b; Daniels, 1966). Portions of the recent volume by Goldston (1965a) are devoted to significant issues connected with this development; for example, How extensive should this new training be? What, exactly, should it include? When should it take place? How can we best introduce it into venerable and entrenched curricula, which are already overstretched (Caplan, 1965d)? Similar problems are encountered in the area of clinical psychology where postdoctoral internships featuring part or extensive exposure to community work are rapidly developing.

Relevant training at the doctoral level is quite limited and, for a variety of reasons, is confined largely to psychology. As recently as several years ago, the results of a survey (Golann, Wurm, & Magoon, 1964) indicated that there was only one formal training program for community psychology in existence, although discrete elements of such training were reflected in a number of clinical programs. Since that time, several new programs have evolved, both in the intradisciplinary and cross-disciplinary traditions. There has also been a marked expansion of community-type offerings in standard clinical training programs to the point where several institutions offer a community "track" as one type of predoctoral specialization available to the clinical student. The substance of these programs, be they "whole" or "part" programs, is variable and is governed largely by the models and conceptions held by the trainers. There is, however, a strongly felt need for training community mental health personnel at the doctoral level, evidenced by the reports of several recent conferences dealing with such matters (Hoch & Raush, 1964; Bennett et al., 1966).

The salient attribute of the program approaches that have been presented in this volume is their newness—measured in terms of the history of science or the history of the helping professions. Accordingly, training precedents are virtually nonexistent. The fact of the matter is the mold is new, and we are not at all clear on how best to train tomorrow's professional (Brigante, 1965; Caplan, 1965b; Srole, 1965). Universities, which to an overwhelming degree govern the nature of professional training, are, in general, not yet ready for this operation. Once a graduate training program becomes fixed, it is extraordinarily difficult to eliminate existing courses and to add new ones. In other words, revamping professional training programs inevitably entails fighting the cumulative inertia of many decades. Sarason et al. (1966), in a remark that combines good humor with archetypic wisdom, have observed: "We are fully aware that changing training programs is a task to be undertaken only by those who need to indulge their masochistic tendencies" (p. 648). Traditional training methods for professionals, though they do not necessarily prepare students for the most needed or most meaningful mental health functions, do have the tremendous advantage of being established, highly operational, and readily communicable. We have had much experience with the Rorschach and the use of "serial sevens" in the diagnostic clinical examination. We believe that we understand what these techniques mean, what their use is, how to teach them, and how to supervise students who are using them. This, intrinsically, gives them a certain aura of "rightness," which in turn means that they are likely to "die hard"!

Much the opposite is true for professional training built on the types of emergent approaches we have been discussing. We are more than hard-pressed to delineate, even if only in moderately clear form, what or how we should be teaching. The entire training situation is a new one; and since its basic dimensions cannot be clearly identified, it is potentially very threatening. Relevant course work is not amply defined; and perhaps more important, we are largely without the types of identification models needed to make this type of learning "come alive" (Caplan, 1965b; Duhl, 1965; Sabshin, 1965). We have little difficulty in recognizing that the types of practicum experience which will be most germane, whether defined in terms of activities or settings, should differ sharply from those heretofore regarded as essential to the training of the mental health specialist. But, as yet we do not have a clear awareness of what these differences should be (Caplan, 1965b). Hopefully, questions about the nature and extent of practicum experiences will be more readily approached as we come to sharpen our ideologies and objectives. We must keep in mind, also, the possibility that emergent practice will lead us logically to institutions, agencies, and settings which, though important conceptually to the furtherance of mental health goals, do not have personnel who are in a position to assume responsibility for professional training.

Given the foregoing ambiguities, it is certain that new developments in the training of mental health professionals will be a slow, mistake-making process characterized by the time-honored attributes of "learning by experience" and "boot-strapping." Such training will have to build on the base of the few concrete models and programs now in existence. Indeed, one of the fundamental purposes of this volume, with its emphasis on the description of concrete programs in action, is to make some of this work better known.

Although the composite picture that we have painted of currently available professional training in this new area might justifiably be described in words such as groping, fragmented, variable, pragmatic, and hastily conceived, let it not be assumed that these terms are necessarily used in a discrediting or pejorative sense. It must be emphasized that these same training programs often flow from a well-spring of open-mindedness, social responsiveness, intellectual curiosity, willingness to explore, and dedicated pursuit. This latter cluster of attitudes and characteristics is the sorely needed substance of new discovery. If the price we must pay for them, at this stage of our development, is some groping and vagueness, then it is still a bargain.

It is well to consider, as realistically as possible, some of the sources of resistance to changes in professional training. There is, first, the problem of intellectual inertia. Many of the new approaches which we have viewed as essential to the improvement of our mental health order will require some breaking away from the routine and humdrum professional acts (e.g., diagnosis and therapy) that our professional ancestors have performed for so long, that we ourselves have been bred to do, and above all, that we have come to feel secure, cozy, and comfortable doing. Understandably, this will not be easy to accomplish. In most instances the behavior of professionals is governed by the conviction that what they are doing now is important, helpful, and the best they can do, whether or not there is an objective basis for such feelings. Accordingly, proposed changes in training are likely to challenge entrenched beliefs and powerful motivational systems.

These cognitive and conative systems are already in evidence even while a person is a student and long before he becomes a functioning professional. Discriminations are quickly made by students among the components of a training program, and value hierarchies are established for these various elements. Some are scorned, some are tolerated as necessary evils, others are accepted because they are clearly instrumental to the performance of higher-order functions; still others are seen as cherished goals—the very zenith of professional function. As a general rule, training in psychotherapy has come to be perceived in the latter light, and there are many who see it as the "be all and end all" of the professional's activities. Indeed it is possible that many individuals go on to graduate training in one of the helping professions primarily to achieve the psychotherapy pinnacle. Where value is so high, the struggle to achieve the objective so great, and the subsequent rewards, in whatever sense, substantial, the function is extraordinarily refractory to extinction in the individual and the perpetuation of the system is assured until a comparable alternative is established.

But the problem goes beyond the strong cathexis that most professionals have for the specifics of their present functions and the fact that they derive much gratification from these. We must go one step further and underscore the fact that the needed alternative roles may often be characterized by attributes which, at least in the short-range sense, reduce their attractiveness. Visible and palpable results of professional effort may extend much further into the future. Means-end contingencies are likely to be blurred, in that it will be much more difficult for the professional to point to a way in which *his* professional actions relate to constructive change in the life situation of a given person who has come to *him* for assistance. A greater proportion of the professional's everyday operations will be relatively impersonal in contrast to the closeness and intimacy of the one-to-one clinical dialogue. This may thwart the gratification of some power and control needs, which, understandably, are important elements in the psychic economy of many professionals. To be at all realistic, it must be recognized that each of the foregoing considerations represents a significant potential source of resistance to change in professional training and function.

How these resistances may be overcome is a vexing problem. That we need to overcome them is suggested in the following statement by Rioch (1966): "If our mental health system is to change in an orderly, evolutionary manner rather than a chaotic revolutionary one, I suggest that the professionals would benefit if they would identify themselves with the advancement of knowledge rather than the practice of a craft, or, if you prefer, of an art. This would leave some very large keys for them and at the same time make it possible for them to unlock the doors for many others" (p. 291). The crux of the matter is that we need to provide a basis for the reorganization of professional goals which does not do violence to the fundamental gratifications of being a professional. Phrased otherwise, the professional must come to believe that only through the utilization of alternative technologies and participation in different types of activities will he do a better, more significant, and more socially utilitarian job. This will not be accomplished by rhetoric, no matter how elegant or convincing, but rather through slow, painstaking accretion of data that provide a compelling basis for reorganization of central values of the professional. For this reason the prime need at the present time is that of doing—of establishing workable and viable programs in the emergent tradition (Caplan, 1965b). Convincing demonstrations of the effectiveness of new approaches will constitute their best "sales pitch" and the prime grounds for modifying professional training. Another salutary outcome of such demonstrations would be the increasing infusion of our influential training centers with knowledgeable, experienced, ego-involved "identification" models who will be in a position to convey conviction and to generate enthusiasm in the process of teaching their students new ways of approaching old problems.

Before concluding this discussion of professional training, there is one additional point to be made, perhaps the most important of all. We can never aspire, even in the best of training programs, to prepare professionals for the full spectrum of situations and challenges that they will be called upon to face in their subsequent careers. There is, in fact, no good way of anticipating what these will be. Therefore, one major emphasis of all professional training should be to develop a healthy skepticism for what is presently assumed to be the proper way of doing things, to foster a problem-solving orientation, and to instill a generalized set of expectations that one will be called on to engage the new and the unexpected. To use a concept which is admittedly overworked these days—and often underspecified—we are speaking of "training for innovation" or, as Reiff (1966) has phrased it, training for "versatility." The essence of both of these concepts is the ability of the professional to implement his conceptual grasp through flexible and constructive adaptations to the novel situation—to be able to recognize, and to capitalize upon, opportunities for utilizing new combinations of skills and resources which seemingly hold promise for the resolution of mental health problems. Such attributes are not likely to be the product of training regimens that are largely technique bound and situation bound.

In the mental health fields, the possibility for innovation will be maximized to the extent that three basic components of professional training are given priority. The first of these is providing the fullest possible understanding of the nature of the issues and the magnitude of the social problems that we face. The second is an emphasis on the development of systematic conceptualizations about the ways in which these problems may be approached. Isolated *ad hoc* solutions may be quite pragmatic, and we may learn a good deal from them. However, the great virtue of a more comprehensive network of conceptualizations is that it provides a basis for transcending the specifics of known and previously encountered situations. As a generalized, orderly, and internally consistent frame of reference, it intrinsically conveys preferred approaches to an almost limitless number of situations which fall within its scope—the new and strange as well as the old. It is of interest to note that the recent Boston training conference (Bennett et al., 1966) placed much emphasis on the term "participant-conceptualizer"—a professional who, through participation in the community process, would have entrée to the special role of "conceptualizing that process within the framework of psychological knowledge and concepts" (p. 19). The last of the three elements is the opportunity to work in close association with models and mentors who, even if not themselves innovators, at least convey in their activities and their teachings a sense of excitement and enthusiasm for engaging the challenges of the unknown.

RESEARCH ASPECTS

As a general proposition, it can be said that the mental health professions have evolved primarily in the clinical rather than the scientific traditions. In these fields, problems of program development are complex and time consuming, demands for service are nearly insatiable, and qualified personnel is lacking. This has caused us, historically, to place relatively lower priorities on research functions and to regard them as something of a luxury to be indulged only in the relatively few favored settings characterized by an affluence of personnel. While this particular hierarchization of values may be adaptive as a response to immediate, day-to-day pressures, as a long-range strategem it can well be self-defeating to the point of guaranteeing fossilization of practice.

Past failures of research to capture either the fancy or the participation of the helping professional stem from two of its basic characteristics—i.e., that the accretion of knowledge through research is both slow and probabilistic. It is of limited comfort for the professional to hear that he may be able to know more about problem X in the vague and distant future when he is obliged to deal with that problem, in maximally certain terms, right now. The relevance and pay-off potential of research is usually so removed from the practitioner that, for him, there is always the illusion of its postponability.

This is not to imply that the mental health fields, particularly when it comes to the evaluation of specific practices and treatment approaches, have been devoid of research. Rather it is to suggest that the research that has been done is characterized by certain critical and recurrent types of shortcomings. The chronicity and seriousness of two of these problems warrant their specific citation. First, since advanced professional training of mental health specialists has not emphasized preparation for research, its products do not ordinarily acquire some rudimentary tools of the trade. As a consequence, substantial portions of the mental health research literature must be seen as unsophisticated and assailable. Such work is often characterized by problems of design, inadequate controls, lack of refinement of technique, and inappropriate criterion measures. Second, and perhaps more insidiously, much of the evaluation of our mental health methods and programs is carried out by professionals who, for any one of a score of reasons, have a very deep stake in the program or system. When impressionistic appraisal is the prime vehicle of evaluation, the dangers of experimenter bias (Orne, 1962; Rosenthal, 1964a, 1964b, 1966) are profound.

To place the matter in a slightly different perspective, the professional, if he is to be effective, must believe in what he is doing and must be invested in his everyday activities. His role, understandably, does not conform to the stereotype of detached objectivity that we have for the scientist. To the extent that he serves simultaneously in the roles of participator and evaluator of a given set of events, he must be regarded as a biased observer for whom certain outcomes, whether consciously or otherwise, may be inimical and unacceptable. Though the observations of the participating professional may represent one admissible source of data, and, indeed, may constitute an especially fertile basis for generating hypothesis, to the extent that they are utilized as the prime vehicle for assessing the effectiveness of methods, we expose ourselves to systematic error that will obstruct progress. Unfortunately, we have, in the past, been forced to depend too heavily on this type of evaluative criterion because it has been the only one available to us. This may be a factor in the perpetuation of technologies or systems in the mental health area that might well have crumbled under more rigorous research scrutiny.

Unquestionably, the principal aims of this volume have been the codification of ideas and conceptions and the description of concrete programs which, seemingly, exemplify emergent approaches to mental health problems. It is apparent that, in striving to meet these objectives, a sense of disappointment and dissatisfaction with the total amount of our societal effort to date in the mental health area has been reflected. Moreover, specific questions have been raised about the defensibility of many current mental health practices; and at least by implication, the charge has been made that the empirical base which justifies such practices is extraordinarily weak.

Much of what we have pointed toward, especially in terms of long-range stratagems and planning, departs significantly from what has been the typical and preferred *modus operandi* in the mental health sphere. At the same time, however, it should be clearly understood that the empirical base for the proposed "new order" is no more substantial than that for the challenged old one. The weight of both our argument and our plea rests squarely upon a vulnerable amalgam of logic and faith. It would be a tragedy were we simply to trade an ancient set of faiths for a new one. What we have sought to establish in this volume is that there is *enough* rationality and logic (and, perhaps, even a slow, beginning trickle of data) to justify increasingly vigorous pursuit of these approaches—that, somehow, the combination of evident shortcomings of the old and promise of the new adds up to a "hunting license" in this area. In the final reckoning, however, the future shape of the mental health order can only be governed by empirics which are, as yet, unknown to us. This means that comprehensive and sophisticated research is a necessity of the highest priority if we are to aspire to sound and orderly progress in the decades to come.

While the problems of inadequate research which have plagued the mental health fields are chronic and generalized ones, there are additional, somewhat particular, reasons which underscore the importance of research in the emergent areas we are considering. As Romano (Ch. 2) observes, the very newness of these approaches causes them to be seized upon, by some, with evangelistic fervor and a totally uncritical attitude. The pathways to truth are hardly made of such components. As a derivative of this point, we may anticipate that some of the multitude of new approaches which are to be explored will be highly susceptible to the so-called "Hawthorne-effects." In other words, the active ingredient of a given program may not be its obvious attributes or substance, but the inordinate energy and enthusiasm of those who are carrying it out. There is nothing *per se* wrong with the latter, except that it may not be sustained in repeated program applications. If that is the case, we are misled through a confounding of form and content, wherein results attributed to the latter are in fact a function of the former. Each of the foregoing is a very real danger for which our best protection is careful research.

It would be illusory and naïve to assume that what has been presented under the banner of emergent approaches has suddenly materialized out of nowhere. While developments of this genre have multiplied appreciably in recent years, precursors, both vestigial and full-blown, have existed for some time. A collective failing of this prior work has been its isolation from the mainstream of knowledge. Often done as demonstration projects or pilot studies in specific settings and lacking any type of research evaluation, the social benefits that have accrued are sharply limited (Freeman & Sherwood, 1965). It is highly probable that the total national investment in such projects has been considerable, but their contributions have not been sufficiently felt and have most certainly been nonadditive. Brooks (1965) develops this same argument as it applies to evaluation of community action programs. Without sound, serious research and its logical by-product—contributions to knowledge in the scientific literature—we are doomed to restricted progress and the wasteful fate of unwittingly retraversing blind alleys. In this sense we can no longer afford not to do good research.

It is disappointing to note that several recent authoritative publications which have addressed themselves to research needs in the mental health area have not done so with sufficient strength. In the summary of the Joint Commission Report (1961), the relevant statement is as follows: "States should be required ultimately to spend 2½ per cent of State mental patient service funds for research" (p. xxii). Given the foregoing expression of values and allocation of monies, one cannot help but wonder whether we are guaranteeing that tomorrow's mental health order will look very much like today's. More recently Smith and Hobbs (1966) in a position paper on the community mental health center adopted by the American Psychological Association propose an annual research expenditure between 5 per cent and 10 per cent of total budget. This recommendation is accompanied by some comments which appear to be highly supportive of research efforts, for example: "Only through explicit appraisal of program effects can worthy approaches be retained and refined, ineffective ones dropped" (p. 508). The force of this sentence, however, is diluted by the one that follows: "Evaluative monitoring of program achievements may vary, of course, from the relatively informal, to the systematic and qualitative, depending on the importance of the issue, the availability of resources, and the willingness of those responsible to take the risks of substituting informed judgment for evidence" (p. 508). The soft spot of this second statement resides in its willingness to anticipate conditions under which research will not or need not be done, or can be done half-heartedly. If this is not the intent of the comment, then its wording is sufficiently ambiguous to allow for interpretation along those lines by those whose values do not prominently feature research.

In our view there is little basis for equivocation where matters of research in the mental health field are concerned. If viable new approaches are to develop, there is urgent need for serious, comprehensive, and entirely "hard-nosed" research. This is true whether we are talking about understanding social systems and their impact on behavior (Freeman & Sherwood, 1965) or about specific mental health-oriented programs such as consultation with care-givers (Cohen, 1966), early secondary prevention in the schools, training of indigenous nonprofessionals, etc. Indeed, it is our conviction that formal research should be built into every program—that it should be regarded as a basic necessity rather than a luxury. Our research technology in the mental health sphere, though far from perfect, has advanced strikingly in the past several decades, and already existing know-how is such that most relevant problems are, indeed, researchable. The real issue then is the value that we come to attach to such functions and the extent to which responsible authority can abet the dignification and perceived meaningfulness of research.

CONCLUDING REMARKS

Few can argue that the cumulative result of prior mental health efforts has been the desired one of substantial reduction of the number and seriousness of mental health problems in modern society. Our greatest failing lies in the imbalanced emphasis that has been placed on the treatment of evident, oftentimes florid, pathology as opposed to efforts directed at stemming the flow of disorder. This failing has been magnified by the circumscribed reach of existing methods as well as by their limited effectiveness. There is greater hope that flow of disorder may be slowed down through modification of influential social systems which shape human development rather than through the one-to-one clinical interaction. Thus, the key to our future mental health welfare is to be found in the fundamental conceptualizations, assumptions, and models that we adopt. As these become more crystallized, many variations in program application will become apparent and "fall into line." In other words, a specific master blueprint does not exist, and there will always be the need for particular tailoring of programs to the needs and attributes of specific settings.

The choice of the word *emergent* in the title of this volume has been a deliberate one. It implies a set of developments which are still very young and very much in process. As such, it also betrays a certain lack of specificity and an incomplete knowledge of the future shape of things. Accordingly, there is need for a high level of tolerance of ambiguity–a willingness to try out and to discard. Throughout, it is essential that such work be researched with dedication and rigor. We are only just beginning to explore models for the training and function of the mental health professional. We also need to understand a great deal more about the potential for utilization of many different types of nonprofessionals in mental health roles. And, much effort must be directed toward effective extension of our mental health programming to the heretofore unreached. This will, necessarily, require the application of new—perhaps as yet unknown–techniques to long-standing, neglected problems.

The one thing that we can be sure of is that we face disappointment, uncertainty, and a constant struggle. Perhaps this is part of the price that must be paid for growth and constructive change. But with emphasis on the community and its primary institutions—especially those affecting the young –a fundamental shift in emphasis to the prevention of disorder, and hard-nosed research, our hopes for making greater strides in the mental health area may be fulfilled.

REFERENCES

Albee, G. W. American psychology in the sixties. *Amer. Psychol.*, 1963, *18*, 90-95.

Allinsmith, W., & Goethals, G. W. *The role of schools in mental health.* New York: Basic Books, 1962.

Baler, L. A. Community mental health: training program in a school of public health. *Comm. Ment. Health J.*, 1965, *1*, 238-244.

Beiser, M. Poverty, social disintegration and personality. *J. soc. Issues*, 1965, *21*, 56-78.

Bellak, L. (Ed.) *Handbook of community psychiatry and community mental health.* New York: Grune & Stratton, 1964. (a)

Bellak, L. Community psychiatry: the third psychiatric revolution. In L. Bellak (Ed.), *Handbook of community psychiatry and community mental health.* New York: Grune & Stratton, 1964. Pp. 1-11. (b)

Bellak, L. A psychiatric training program for general practitioners and nonpsychiatric specialists. In L. Bellak (Ed.), *Handbook of community psychiatry and community mental health.* New York: Grune & Stratton, 1964. Pp. 280-296. (c)

Bennett, C. C., Anderson, L. S., Cooper, S., Hassol, L., Klein, D. C., & Rosenblum, G. (Eds.), *Community psychology: a report of the Boston conference on the education of psychologists for community mental health.* Boston: Boston University Press, 1966.

Berlin, I. N. Training in community psychiatry: its relation to clinical psychiatry. *Comm. Ment. Health J.*, 1965, *1*, 357-360.

Bernard, V. W. Community psychiatry in a university medical center (with emphasis on the rationale and objectives of training). In L. Bellak (Ed.), *Handbook of community psychiatry and community mental health.* New York: Grune & Stratton, 1964. Pp. 82-122.

Bernard, V. W. Some aspects of training for community psychiatry in a university medical center. In S. E. Goldston (Ed.), *Concept of community psychiatry: a framework for training.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1319, 1965. Pp. 57-68.

Biber, B. Integration of mental health principles in the school setting. In G. Caplan (Ed.), *Prevention of mental disorders in children.* New York: Basic Books, 1961. Pp. 323-352.

Bloom, B. L. The "medical model," miasma theory and community mental health. *Comm. Ment. Health J.*, 1965, *1*, 333-338.

Bower, E. M. *Early identification of emotionally handicapped children.* Springfield, Ill.: Charles C Thomas, 1960.

Bower, E. M. Primary prevention in a school setting. In G. Caplan (Ed.), *Prevention of mental disorders in children.* New York: Basic Books, 1961. Pp. 353-377.

Bower, E. M. Primary prevention of emotional disorders: a conceptual framework and action possibilities. *Amer. J. Orthopsychiat.*, 1963, 33, 832-848.

Bower, E. M. The modification, mediation and utilization of stress during the school years. *Amer. J. Orthopsychiat.*, 1964, 34, 667-674.

Bower, E. M. Primary prevention of mental and emotional disorders. In N. M. Lambert (Ed.), *The protection and promotion of mental health in schools.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1226, 1965. Pp. 1-9.

Bower, E. M., & Lambert, N. M. *A process for in-school screening of children with emotional handicaps.* Sacramento, Calif.: Calif. State Dept. of Educ., 1961.

Bower, E. M., Shellhamer, T. A., & Dailey, J. M. School characteristics of male adolescents who later became schizophrenic. *Amer. J. Orthopsychiat.*, 1960, 30, 712-729.

Bower, E. M., Tashnovian, P. J., & Larson, C. A. *A process for early identification of emotionally disturbed children.* Sacramento, Calif.: Calif. State Dept. of Educ., 1958.

Brager, G. New concepts and patterns of service: the Mobilization for Youth program. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor.* New York: Free Press, 1964. Pp. 412-421.

Brigante, T. R. Opportunities for community mental health training within the residential college campus context. *Comm. Ment. Health J.*, 1965, *1*, 55-60.

Briggs, D. L. Convicted felons as innovators in a social development project. In *Experiment in culture expansion.* Sacramento, Calif.: Calif. Dept. of Corrections, 1963. Pp. 83-90.

Brim, O. G. Methods of educating parents and their evaluation. In G. Caplan (Ed.), *Prevention of mental disorders in children.* New York: Basic Books, 1961. Pp. 122-141.

Brooks, M. P. The community action program as a setting for applied research. *J. soc. Issues*, 1965, *21*, 29-40.

California Department of Corrections. *Experiment in culture expansion.* Sacramento, Calif.: Calif. Dept. of Corrections, 1963.

Caplan, G. Mental health consultation in the schools. In *The elements of a community mental health program.* New York: Milbank Memorial Fund, 1956. Pp. 77-85.

Caplan, G. *Concepts of mental health and consultation.* Washington, D.C.: U.S. Dept. of H.E.W., Children's Bureau Public. No. 373, 1959. (a)

Caplan, G. An approach to the education of community mental health specialists. *Ment. Hygiene*, 1959, 43, 268-280. (b)

Caplan, G. Patterns of parental response to the crisis of premature birth. *Psychiatry*, 1960, 23, 365-374.

Caplan, G. *An approach to community mental health.* New York: Grune & Stratton, 1961.

Caplan, G. Types of mental health consultation. *Amer. J. Orthopsychiat.*, 1963, 33, 470-481.

Caplan, G. *Principles of preventive psychiatry.* New York: Basic Books, 1964. (a)

Caplan, G. Beyond the child guidance clinics. *Working Papers in Comm. Ment. Health*, 1964, 2, 1-12. (b)

Caplan, G. The role of pediatricians in community mental health (with particular reference to the primary prevention of mental disorders in children). In L.

Bellak (Ed.), *Handbook of community psychiatry and community mental health.* New York: Grune & Stratton, 1964. Pp. 287-299. (c)

Caplan, G. Opportunities for school psychologists in primary prevention of emotional disorders of children. In N. M. Lambert (Ed.), *The protection and promotion of mental health in schools.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1226, 1965. Pp. 9-22. (a)

Caplan, G. Community psychiatry—introduction and overview. In S. E. Goldston (Ed.), *Concepts of community psychiatry: a framework for training.* U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1319, 1965. Pp. 3-18. (b)

Caplan, G. Problems of training in mental health consultation. In S. E. Goldston (Ed.), *Concepts of community psychiatry: a framework for training.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1319, 1965. Pp. 91-108. (c)

Caplan, G. Current issues relating to the training of psychiatric residents in community psychiatry. In S. E. Goldston (Ed.), *Concepts of community psychiatry: a framework for training.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1319, 1965. Pp. 167-182. (d)

Clausen, J. A. A sociological perspective. In R. Brockbank & D. Westby-Gibson (Eds.), *Mental health in a changing community.* New York: Grune & Stratton, 1966. Pp. 13-17.

Cohen, L. D. Strategies and logistics in mental health research. In C. C. Bennett, L. S. Anderson, S. Cooper, L. Hassol, D. C. Klein, & G. Rosenblum (Eds.), *Community psychology: a report of the Boston conference on the education of psychologists for community mental health.* Boston: Boston University Press, 1966. Pp. 65-79.

Cottrell, L. S. Social planning, the competent community and mental health. In *Urban America and the planning of mental health services.* New York: Group for Advancement of Psychiatry, 1964. Pp. 391-402.

Cowen, E. L., Beach, D. R., Izzo, L. D., Laird, J. D., Rappaport, J. D., Trost, M. A., & Zax, M. Early diagnosis of emotional disorder in the school setting: a follow-up study. 1968 (in press).

Cowen, E. L., Izzo, L. D., Miles, H., Telschow, E. F., Trost, M. A., & Zax, M. A preventive mental health program in the school setting: description and evaluation. *J. Psychol.*, 1963, *56*, 307-356.

Cowen, E. L., Zax, M., Izzo, L. D., & Trost, M. A. Prevention of emotional disorders in the school setting: a further investigation. *J. consult. Psychol.*, 1966, *30*, 381-387. (a)

Cowen, E. L., Zax, M., & Laird, J. D. A college student volunteer program in the elementary school setting. *Comm. Ment. Health J.*, 1966, *2*, 319-328. (b)

Cytryn, L., & Uihlein, A. Training of volunteers in the field of mental retardation—an experiment. *Amer. J. Orthopsychiat.*, 1965, *35*, 493-499.

Daniels, R. S. Community psychiatry—a new profession, a developing subspeciality, or effective clinical psychiatry? *Comm. Ment. Health J.*, 1966, *2*, 47-54.

Daniels, R. S., & Margolis, P. M. Community psychiatry in a traditional psychiatric residency. In S. E. Goldston (Ed.), *Concepts of community psychiatry: a framework for training.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1319, 1965. Pp. 69-78.

Deutsch, M. P. The disadvantaged child and the learning process. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor.* New York: Free Press, 1964. Pp. 172-187.

Donahue, G. T., & Nichtern, S. *Teaching the troubled child.* New York: Free Press, 1965.

Duggan, J. N. An example of secondary prevention activities in the schools: talent searching in a culturally deprived population. In N. M. Lambert (Ed.), *The protection and promotion of mental health in schools.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1226, 1965. Pp. 48-52.

Duhl, L. J. (Ed.) *The urban condition.* New York: Basic Books, 1963.

Duhl, L. J. The psychiatric evolution. In S. E. Goldston (Ed.), *Concepts of community psychiatry: a framework for training.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1319, 1965. Pp. 19-32.

Dunham, H. W. Community psychiatry: the newest therapeutic bandwagon. *Arch. gen. Psychiat.,* 1965, *12,* 303-313.

Eisenberg, L. The strategic deployment of the child psychiatrist. *J. child Psychol. & Psychiat.,* 1961, 2, 229-241.

Eisenberg, L. Possibilities for a preventive psychiatry. *Pediatrics,* 1962, *30,* 815-828. (a)

Eisenberg, L. If not now, when? *Amer. J. Orthopsychiat.,* 1962, 32, 781-793. (b)

Eisenberg, L., & Gruenberg, E. M. The current status of secondary prevention in child psychiatry. *Amer. J. Orthopsychiat.,* 1961, *31,* 355-367.

Erikson, E. H. *Identity and the life cycle.* New York: International Universities Press, *Psychol. Issues Monogr.* No. 1, 1959.

Fantl, B. Preventive intervention. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor.* New York: Free Press, 1964. Pp. 362-370.

Felix, R. H. (Ed.) *Mental health activities and the development of comprehensive health programs in the community.* Washington, D.C.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 905, 1962.

Fellows, L., & Wolpin, M. High school psychology trainees in a mental hospital. In *The use of nonprofessional and preprofessional personnel as a partial solution to the manpower shortage.* Camarillo, Calif.: Camarillo State Hosp., 1966. Pp. 1-5.

Fishman, J. R., Klein, W. L., MacLennan, B. W., Mitchell, L., Pearl, A., & Walker, W. *Training for new careers.* Washington, D.C.: President's Committee on Juvenile Delinquency and Youth Crime, 1965.

Freeman, H. E., & Sherwood, C. C. Research in large scale intervention programs. *J. soc. Issues,* 1965, *21,* 11-28.

Gildea, M. C-L. *Community mental health.* Springfield, Ill.: Charles C Thomas, 1959.

Glasscote, R. M., Sanders, D., Forstenzer, H. M., & Foley, A. R. *The community mental health center: an analysis of existing models.* Washington, D.C.: Amer. Psychiat. Ass'n., 1964.

Glidewell, J. C. (Ed.) Mental health in the classroom. *J. soc. Issues,* 1959, *15,* Whole No. 1.

Glidewell, J. C. (Ed.) *Parental attitudes and child behavior.* Springfield, Ill.: Charles C Thomas, 1961.

Glidewell, J. C. Perspectives in community health. In C. C. Bennett, L. S. Anderson, S. Cooper, L. Hassol, D. C. Klein, & G. Rosenblum (Eds.), *Community psychology: a report of the Boston conference on the education of psychologists for community mental health*. Boston: Boston University Press, 1966. Pp. 33-49.

Goffman, E. *Asylums*. Garden City, N.Y.: Doubleday, 1961.

Golann, S. E., Wurm, C., & Magoon, T. M. Community mental health content in the graduate program in departments of psychology. *J. clin. Psychol.*, 1964, *20*, 518-522.

Goldston, S. E. (Ed.) *Concepts of community psychiatry: a framework for training*. Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1319, 1965. (a)

Goldston, S. E. Training in community psychiatry: a survey report of the chairmen of medical school departments of psychiatry. In S. E. Goldston (Ed.), *Concepts of community psychiatry: a framework for training*. Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Report No. 1319, 1965. Pp. 185-194. (b)

Greenblatt, M. A role for the voluntary organizations in the work of mental health institutions. In *College student companion program: contribution to the social rehabilitation of the mentally ill*. Hartford, Conn.: Conn. State Dept. of Ment. Health, 1962. Pp. 10-19.

Greenblatt, M., & Kantor, D. The student volunteer movement and the manpower shortage. *Amer. J. Psychiat.*, 1961, *118*, 809-814.

Greenblatt, M., & Levinson, D. J. Mental hospitals. In B. Wolman (Ed.), *Handbook of clinical psychology*. New York: McGraw-Hill, 1965. Pp. 1343-1359.

Gurin, G., Veroff, J., & Feld, S. *Americans view their mental health: a nationwide interview survey*. New York: Basic Books, 1960.

Hawkinshire, F. B. W. Training needs for offenders working in community treatment programs. In *Experiment in culture expansion*. Sacramento, Calif.: Calif. Dept. of Corrections, 1963. Pp. 27-36.

Haylett, C. H., & Rapoport, L. Mental health consultation. In L. Bellak (Ed.), *Handbook of community psychiatry and community mental health*. New York: Grune & Stratton, 1964. Pp. 319-339.

Hereford, C. F. *Changing parental attitudes through group discussion*. Austin, Texas: University of Texas Press, 1963.

Hobbs, N. Mental health's third revolution. *Amer. J. Orthopsychiat.*, 1964, *34*, 822-833.

Hoch, E. L., & Raush, H. L. *Conference on responsibilities of universities for clinical training to meet state and regional mental health needs*. Ann Arbor, Mich.: Univer. of Michigan Press, 1964.

Hoch, E. L., Ross, A. O., & Winder, C. L. (Eds.), *Professional preparation of clinical psychologists*. Washington, D.C.: American Psychol. Ass'n., 1966.

Hollister, W. G. The concept of "strens" in preventive interventions and ego-strength building in the schools. In N. M. Lambert (Ed.), *The protection and promotion of mental health in schools*. Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1226, 1965. Pp. 30-35.

Holzberg, J. D. The significance of the companionship experience for the college student. In *College student companion program: contribution to the social* *rehabilitation of the mentally ill.* Hartford, Conn.: Conn. State Dept. of Ment. Health, 1962. Pp. 39-48.

Holzberg, J. D. The companion program: implementing the manpower regulations of the Joint Commission on Mental Illness and Health. *Amer. Psychol.*, 1963, *18*, 224-226.

Holzberg, J. D., & Knapp, R. H. The social interaction of college students and chronically ill mental patients. *Amer. J. Orthopsychiat.*, 1965, *35*, 487-492.

Hubbard, F. D. The youth consultant project of the program for detached workers, Young Men's Christian Association of metropolitan Chicago. In *Experiment in culture expansion.* Sacramento, Calif.: Calif. Dept. of Corrections, 1963. Pp. 65-72.

Huessy, H. R. (Ed.) *Mental health with limited resources: Yankee ingenuity in low-cost programs.* New York: Grune & Stratton, 1966. (a)

Huessy, H. R. Spring Lake Ranch—the pioneer halfway house. In H. R. Huessy (Ed.), *Mental health with limited resources: Yankee ingenuity in low-cost programs.* New York: Grune & Stratton, 1966. Pp. 63-72. (b)

Huessy, H. R. Exciting possibilities for secondary prevention. In H. R. Huessy (Ed.), *Mental health with limited resources: Yankee ingenuity in low-cost programs.* New York: Grune & Stratton, 1966. Pp. 113-119. (c)

Hume, P. B. Principles and practices of community psychiatry: the role and training of the specialist in community psychiatry. In L. Bellak (Ed.), *Handbook of community psychiatry and community mental health.* New York: Grune & Stratton, 1964. Pp. 65-81.

Joint Commission on Mental Illness and Health. *Action for mental health.* New York: Basic Books, 1961.

Kantor, D. Impact of college students on chronic mental patients and on the organization of the mental hospital. In *College student companion program: contribution to the social rehabilitation of the mentally ill.* Hartford, Conn.: Conn. State Dept. of Ment. Health, 1962. Pp. 28-38.

Kazanjian, V., Stein, S., & Weinberg, W. L. *An introduction to mental health consultation.* Washington, D.C.: U.S. Dept. of H.E.W., Public Health Monogr. No. 69, 1962.

Kelley, J. G. The mental health agent in the urban community. In *Urban America and the planning of mental health services.* New York: Group for Advancement of Psychiatry, 1964. Pp. 474-494.

Kelley, J. G. Ecological constraints on mental health services. *Amer. Psychol.*, 1966, *21*, 535-539.

Kiesler, F. Is this psychiatry? In S. E. Goldston (Ed.), *Concepts of community psychiatry: a framework for training.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1319, 1965. Pp. 147-157.

Klein, D. C. An example of primary prevention activities in the schools: working with parents in preschool and early school years children. In N. M. Lambert (Ed.), *The protection and promotion of mental health in schools.* Bethesda, Md.: Dept. of H.E.W., Public Health Serv. Public. No. 1226, 1965. Pp. 42-47.

Klein, W. L., & Zax, M. The use of a hospital volunteer program in the teaching of abnormal psychology. *J. soc. Psychol.*, 1965, *65*, 155-165.

Krugman, M. (Ed.) *Orthopsychiatry and the schools.* New York: Amer. Orthopsychiat. Ass'n., 1958.

Ladieu, G., Hanfmann, E., & Dembo, T. Studies in adjustment to visible injuries: evaluation of help by the injured. *J. abnorm. soc. Psychol.,* 1947, *42,* 169-192.

Lambert, N. M. (Ed.) *The protection and promotion of mental health in the schools.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1226, 1965. (a)

Lambert, N. M. Applications of the taxonomy of "stress" in specific school situations. In N. M. Lambert (Ed.), *The protection and promotion of mental health in schools.* Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public No. 1226, 1965. Pp. 36-41. (b)

Lazarus, R. S. *Psychological stress and the coping process.* New York: McGraw-Hill, 1966.

Leighton, A. H. *An introduction to social psychiatry.* Springfield, Ill.: Charles C Thomas, 1960.

Levine, R. A. Treatment in the home: an experiment with low income, multiproblem families. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor.* New York: Free Press, 1964. Pp. 329-335.

Levitt, E. E. The results of psychotherapy with children: an evaluation. *J. consult. Psychol.,* 1957, *21,* 189-196.

Lewin, K. *Principles of topological psychology.* New York: McGraw-Hill, 1936.

Libo, L. M., & Griffith, C. R. Developing mental health programs in areas lacking professional facilities: the community consultant approach in New Mexico. *Comm. Ment. Health J.,* 1966, *2,* 163-169.

Lindemann, E. Symptomatology and management of acute grief. *Amer. J. Psychiat,* 1944, *101,* 141-148.

MacLennan, B. W., Klein, W. L., Pearl, A., & Fishman, J. R. Training for new careers. *Comm. Ment. Health J.,* 1966, *2,* 135-141.

Meyerson, L. Somatopsychology of physical disability. In W. M. Cruickshank (Ed.), *Psychology of exceptional children and youth.* (2nd ed.) New York: Prentice-Hall, 1963. Pp. 1-52.

Mitchell, W. E. Fictive siblings and the "unworthy" child in changing rural Vermont. *Amer. J. Orthopsychiat.,* 1964, *34,* 265-366.

Mitchell, W. E. The use of college student volunteers in the outpatient treatment of troubled children. In H. R. Huessy (Ed.), *Mental health with limited resources: Yankee ingenuity in low-cost programs.* New York: Grune & Stratton, 1966. Pp. 28-37.

Nichols, R. S. The influence of economic and administrative factors on the type and quality of care given to persons with psychological disease. *Working Papers in Comm. Ment. Health,* 1963, *1,* 1-34.

Oberhauser, E. J. Inmates as treaters in the therapeutic community setting. In *Experiment in culture expansion.* Sacramento, Calif.: Calif. Dept. of Corrections, 1963. Pp. 97-100.

Ojemann, R. H. Investigations on the effects of teaching and understanding and appreciation of behavior dynamics. In G. Caplan (Ed.), *Prevention of mental disorders in children.* New York: Basic Books, 1961. Pp. 378-397.

O'Neal, P., & Robbins, L. N. The relation of childhood behavior problems to adult psychiatric status: a 30-year follow-up of 150 subjects. *Amer. J. Psychiat.*, 1958, *114*, 961-969. (a)

O'Neal, P., & Robbins, L. N. Childhood patterns predictive of adult schizophrenia: a 30-year follow-up. *Amer. J. Psychiat.*, 1958, *115*, 385-391. (b)

Onondaga County School Studies, Interim report No. 1. *Persistence of emotional disturbances reported among second and fourth grade children.* Syracuse, N.Y.: N.Y. State Dept. of Mental Hygiene, Mental Health Res. Unit, 1964.

Orne, M. T. On the social psychology of the psychological experiment: with particular reference to demand characteristics and their implications. *Amer. Psychol.*, 1962, *17*, 776-783.

Pearl, A., & Riessman, F. *New careers for the poor.* New York: Free Press, 1965.

Peck, H. B., Harrower, M., & Beck, M. B. *A new pattern for mental health services in a children's court.* Springfield, Ill.: Charles C Thomas, 1958.

Peck, H. B., Kaplan, S. R., & Roman, M. Prevention, treatment and social action: a strategy of intervention in a disadvantaged urban area. *Amer. J. Orthopsychiat.*, 1966, *36*, 57-69.

Poser, E. G. The effect of therapist training on group therapeutic outcome. *J. consult. Psychol.*, 1966, *30*, 283-289.

Rae-Grant, Q. A. F., Gladwin, T., & Bower, E. M. Mental health, social competence and the war on poverty. *Amer. J. Orthopsychiat.*, 1966, *36*, 652-664.

Reiff, R. The ideological and technological implications of clinical psychology. In C. C. Bennett, L. S. Anderson, S. Cooper, L. Hassol, D. C. Klein, & G. Rosenblum (Eds.), *Community psychology: a report of the Boston conference on the education of psychologists for community mental health.* Boston: Boston University Press, 1966. Pp. 51-64.

Reiff, R., and Riessman, F. The indigenous nonprofessional: a strategy of change in community action and community mental health programs. *Comm. Ment. Health J.*, Monogr. No. 1, 1965.

Reinherz, H. College student volunteers as case-aides in a state hospital for children. *Working Papers in Comm. Ment. Health*, 1963, *1*, 35-49. (a)

Reinherz, H. College student volunteers as case-aides in a state hospital for children. *Amer. J. Orthopsychiat.*, 1963, *33*, 544-546. (b)

Riessman, F. The "helper" therapy principle. *Social Work*, 1965, *10*, 27-32.

Riessman, F., Cohen, J., & Pearl, A. (Eds.) *Mental health of the poor.* New York: Free Press, 1964.

Riessman, F., & Goldfarb, J. Role playing and the poor. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor.* New York: Free Press, 1964. Pp. 336-347.

Rioch, M. J. Changing concepts in the training of psychotherapists. *J. consult. Psychol.*, 1966, *30*, 290-292.

Rioch, M. J., Elkes, C., Flint, A. A., Usdansky, B. S., Newman, R. G., & Silber, E. National Institute of Mental Health pilot study in training of mental health counselors. *Amer. J. Orthopsychiat.*, 1963, *33*, 678-689.

Robinson, R., DeMarche, D. F., & Wagle, M. K. *Community resources in mental health.* New York: Basic Books, 1961.

Rockefeller, W. New roles for trained volunteer workers in mental health. In R. L. Sutherland & B. K. Smith (Eds.), *Understanding mental health: a* *common need, a less frequent achievement*. Princeton, N.J.: Van Nostrand, 1965. Pp. 167-174.

Rosenbaum, M. Some comments on the use of untrained therapists. *J. consult. Psychol.*, 1966, *30*, 292-294.

Rosenthal, R. Experimenter outcome-orientation and the results of the psychological experiment. *Psychol. Bull.*, 1964, *61*, 405-412. (a)

Rosenthal, R. The effect of the experimenter on the results of psychological research. In B. A. Maher (Ed.), *Progress in experimental personality research*. Vol. I. New York: Academic Press, 1964. Pp. 79-114. (b)

Rosenthal, R. *Experimenter effects in behavioral research*. New York: Appleton-Century-Crofts, 1966.

Sabshin, M. Theory and practice of community psychiatry training in the medical school setting. In S. E. Goldston (Ed.), *Concepts of community psychiatry: a framework for training*. Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1319, 1965. Pp. 49-56.

Sanford, N. The prevention of mental illness. In B. Wolman (Ed.), *Handbook of clinical psychology*. New York: McGraw-Hill, 1965. Pp. 1378-1400. (a)

Sanford, N. Ego processes in learning. In N. M. Lambert (Ed.), *The protection and promotion of mental health in the schools*. Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1226, 1965. Pp. 22-29. (b)

Sarason, S. B., Davidson, K., & Blatt, B. *The preparation of teachers: an unstudied problem in education*. New York: Wiley, 1962.

Sarason, S. B., Levine, M., Goldenberg, I. I., Cherlin, D. L., & Bennett, E. M. *Psychology in community settings*. New York: Wiley, 1966.

Schofield, W. *Psychotherapy: the purchase of friendship*. Englewood Cliffs, N.J.: Prentice-Hall, 1964.

Schwitzgebel, R. R. Delinquents with tape recorders. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor*. New York: Free Press, 1964. 582-588.

Sheeley, W. F. The general practitioner's contribution to community psychiatry. In L. Bellak (Ed.), *Handbook of community psychiatry and community mental health*. New York: Grune & Stratton, 1964. Pp. 268-279.

Slack, C. W. SCORE: a description. In *Experiment in culture expansion*. Sacramento, Calif.: Calif. Dept. of Corrections, 1963. Pp. 59-64.

Smith, M. B., & Hobbs, N. The community and the community mental health center. *Amer. Psychol.*, 1966, *21*, 499-509.

Spiegal, A. D. (Ed.) *The mental health role of settlement houses and community centers*. Boston: Mass. Dept. of Mental Health, 1964.

Srole, L. Selected sociological perspectives. In S. E. Goldston (Ed.), *Concepts of community psychiatry: a framework for training*. Bethesda, Md.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 1319, 1965. Pp. 33-46.

Stennett, R. G. Emotional handicap in the elementary years: phase or disease. *Amer. J. Orthopsychiat.*, 1965, 35, 444-449.

Torrance, E. P. & Strom, R. D. (Eds.) *Mental health and achievement: increasing potential and reducing school dropout*. New York: Wiley, 1965.

Umbarger, C. C., Dalsimer, J. S., Morrison, A. P., & Breggin, P. R. *College students in a mental hospital*. New York: Grune & Stratton, 1962.

Volkman, R., & Cressey, D. R. Differential association and the rehabilitation of drug addicts. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor*. New York: Free Press, 1964. Pp. 600-619.

Westby-Gibson, D. The schools. In R. Brockbank & D. Westby-Gibson (Eds.), *Mental health in a changing community*. New York: Grune & Stratton, 1966. Pp. 76-82.

Westman, J. C., Rice, D. L., & Bermann, E. Nursery school behavior and later school adjustment. *Amer. J. Orthopsychiat.*, 1967, 37, 725-731.

Williams, R. H. (Ed.) *The prevention of disability in mental disorders*. Washington, D.C.: U.S. Dept. of H.E.W., Public Health Serv. Public. No. 926, 1962.

Wright, B. A. *Physical disability—a psychological approach*. New York: Harper & Row, 1960.

Yablonsky, L., & Dederich, C. E. Synanon: as a program for training ex-offenders as therapeutic agents. In *Experiment in culture expansion*. Sacramento, Calif.: Calif. Dept. of Corrections, 1963. Pp. 37-48.

Zax, M., Cowen, E. L., Izzo, L. D., Madonia, A. J., Merenda, J., & Trost, M. A. A teacher aide program for preventing emotional disturbance in young school children. *Ment. Hygiene*, 1966, 50, 406-415.

Zax, M., Cowen, E. L., Izzo, L. D., & Trost, M. A. Identifying emotional disturbance in the school setting. *Amer. J. Orthopsychiat.*, 1964, 34, 447-454.

AUTHOR INDEX

Albee, G. W., 11, 14, 24, *26*, 63, 66, 67, 72, 128, *143*, 214, *235*, 353, *368*, 417, *446*
Alexander, F. G., 3, *26*
Allinsmith, W., 271, 289, 404, 405, 408, *446*
Allison, R. B., 49, *60*
Allport, G. W., 46, 47, 59, *59*
Altrocchi, J., 217, 218, 221, *235*
Amster, F., 291, *305*
Anderson, A. R., 47, 52, *59*
Anderson, J. K., 50, *60*
Anderson, L. S., 433, 435, 437, 441, *446*
Armstrong, R. A., 14, *28*
Arsenian, J., 18, *26*
Auld, F., 185, *211*

Babayan, E. E., 210, *211*
Babigian, H. M., 195, *211*
Bahn, A. K., 186, *212*, 233, *236*
Baler, L. A., 436, *446*
Barker, R. G., 363, *368*
Beach, D. R., 409, *448*
Beach, H. D., 55, *59*
Bean, L. L., 49, *61*
Beck, M. B., 405, *453*
Beiser, M., 402, 403, *446*
Bellak, L., 8, 10, *26*, 398, 415, 431, *446*
Bemmels, V. G., 196, *211*
Bennett, C. C., 433, 435, 437, 441, *446*, *453*
Bennett, E. M., 8, 9, 12, *29*, 402, 404, 405, 435, 437, *454*
Berelson, B., 266, *268*
Berlin, I. N., 209, *211*, 219, 221, 230, *235*, 286, 289, 433, *446*
Bermann, E., 410, *455*
Bernard, V. W., 433, 437, *446*
Biber, B., 241, 242, *251*, 254, 255, *268*, 405, *446*
Bierer, J., 130, *143*
Bindman, A. J., 216, 217, *236*, 315, *329*
Bindra, D., 17, *26*
Bion, W. R., 130, *143*
Blackford, L, 209, *212*
Blatt, B., 405, *454*
Bloch, D. A., 55, *61*
Bloom, B. L., 392, 394, *446*
Bockoven, J. S., 75, *87*
Bower, E. M., 18, *26*, 259, *268*, 325, *329*, 403, 405, 406, 408, 410, 416, *446*, *447*, *453*
Brager, G., 174, *184*, 402, 422, *447*
Branch, C. H. H., 49, *60*
Bredemeier, H. C., 20, *26*
Breggin, P. R., 91, *109*, 421, 424, 427, *454*
Breiter, D., 121, *127*
Brigante, T. R., 437, *447*
Briggs, D. L., 423, *447*
Brill, N. Q., 49, *60*, 186, *212*
Brim, O. G., 363, *368*, 404, *447*
Brooks, M. P., 443, *447*
Brown, B. S., 11, 22, *26*, *29*
Brown, E. L., 130, *143*
Brown, G. W., 53, *60*
Bruner, J. S., 44, *60*, 257, 258, *268*
Buchmueller, A. D., 296, 302, *305*
Buell, B., 196, *212*
Bullis, H. E., 253, *268*
Burgess, M. E., 10, *26*
Burnes, A. J., 263, 264, *268*

Cain, H. P., 11, *26*
Campbell, D. T., 50, *60*
Cantril, H., 57, *60*
Caplan, G., 9, 11, 12, 17, 18, 22, *26*, 55, *60*, 81, *87*, 171, 172, 181, *184*, 216, 217, 219, *236*, 311, 315, *329*, 404, 406, 407, 408, 412, 413, 415, 434, 436, 437, 438, 440, *447*, *448*
Carstairs, G. M., 53, *60*

Carter, J. W., 233, *236*
Cartwright, D. S., 17, *26*
Cartwright, R., 254, *268*
Castaneda, A., 208, *212*
Cherlin, D. L., 8, 9, 12, 29, 402, 404, 405, 435, 437, *454*
Chope, H. D., 209, *212*
Clark, W. W., 265, *270*
Clausen, J. A., 10, 19, *27*, 402, 403, *448*
Cohen, J., 17, 19, *29*, 402, 453
Cohen, L. D., 444, *448*
Cole, N. J., 49, *60*
Coleman, J. S., 286, *289*
Coleman, S. H., 200, *212*
Cooley, W. W., 260, 268
Cooper, S., 433, 435, 437, 441, *446*
Cottrell, L. S., 390, *448*
Cowen, E. L., 14, 25, *27*, 208, *212*, 331, 332, 348, *351*, 405, 409, 422, 423, 424, 425, 427, 429, *448*, *455*
Cressey, D. R., 428, *454*
Cumming, E., 52, 53, 55, 56, *60*, *61*
Cumming, J., 24, 52, 55, 56, *60*
Cutler, R. L., 275, 277, 279, 289
Cytryn, L., 421, *448*

Dailey, J. M., 410, *447*
Dalsimer, J. S., 91, *109*, 421, 424, 427, *454*
Daniels, R. S., 437, *448*
Davidson, K., 405, *454*
Davis, J., 53, *60*
Davis, K., 186, 201, *212*
DeCharms, R., 17, 27
Dederich, C. E., 428, *455*
DeMarche, D. F., 414, 453
Dembo, T., 406, *452*
Deutsch, M. P., 403, *449*
Dohrenwend, B. P., 57, *60*
Dohrenwend, B. S., 57, *60*
Domke, H. R., 295, 296, 298, 302, *305*, *306*
Donahue, G. T., 25, 377, 379, *386*, 422, *449*
Duggan, J. N., 416, *449*
Duhl, L. J., 7, 15, *27*, 81, *87*, 148, *161*, 402, 434, 438, *449*
Dunham, H. W., 8, *27*, 36, 37, 39, 185, 191, 192, *212*, 401, *449*
Durkheim, E., 172, *184*

Ebner, E., 104, *109*
Eisdorfer, C., 217, 218, 221, *235*
Eisenberg, L., 7, 9, 10, 13, 16, 17, 18, *27*, 407, 411, 417, *449*
Elkes, C., 81, *88*, 113, *127*, 421, 453
Empey, L. T., 150, *161*
Erikson, E. H., 47, 52, 54, 56, 58, *60*, 406, *449*
Ewalt, J. R., 49, *60*
Eysenck, H. J., 16, 17, 27

Fairweather, G., 10, 27
Fantl, B., 403, *449*
Faris, R. E. L., 185, 191, 192, *212*
Feld, S., 13, 28, 411, 412, *450*
Felix, R. H., 11, 18, *27*, 232, *236*, 417, 434, *449*
Fellows, L., 421, *449*
Fishman, J. R., 144, 146, 147, 148, 150, 156, 160, *161*, 422, 423, *449*, 452
Fiske, D. W., 50, *60*
Fitzgerald, B., 132, *143*
Flint, A. A., 81, *88*, 113, *127*, 421, 453
Foley, A. R., 9, 11, 22, *27*, 397, 411, *449*
Forstenzer, H. M., 9, 11, 22, *27*, 397, 411, *449*
Foucault, M., 5, 27
Fox, R., 255, *269*
Frank, J. D., 49, *62*
Franklin, M., 242, *251*
Freedman, A. M., 9, 27
Freeman, H. E., 40, 53, *60*, 443, 444, *449*
Freud, S., 45, *60*, 201, *212*
Fried, M., 19, 27, 57, *60*
Friedman, S. T., 25, 318, 323, *330*

Gardner, E. A., 24, 186, 195, 196, 208, *211*, *212*

Gewirtz, H., 102, 104, *108*, *109*
Gildea, M. C.-L., 25, 290, 291, 295, 296, 299, 302, *305*, *306*, 315, *329*, 346, *351*, 404, *449*
Gilkerson, E., 254, *268*
Ginsburg, S. W., 50, *60*
Ginzberg, E., 50, *60*
Gladwin, T., 403, *453*
Glass, A. J., 42, 57, 58, *60*
Glasscote, R. M., 9, 11, 22, 27, 35, 39, 397, 411, *449*
Glidewell, J. C., 25, 208, *212*, 296, 298, 299, 302, *305*, *306*, 346, *351*, 401, 404, *449*, *450*
Goethals, G. W., 271, *289*, 404, 405, 408, *446*
Goffman, E., 10, 19, 27, 78, *87*, 398, *450*
Golann, S. E., 121, *127*, 437, *450*
Goldenberg, I. I., 8, 9, 12, *29*, 402, 404, 405, 435, 437, *454*
Goldfarb, J., 422, *453*
Goldston, S. E., 16, 27, 433, 436, 437, *450*
Gordon, J., 48, *60*, 81, *87*
Greenblatt, M., 10, *28*, 91, 100, *108*, 130, *143*, 398, 421, *450*
Griffith, C. R., 214, *236*, 414, *452*
Gross, R., 258, *269*
Gruenberg, E. M., 411, *449*
Gump, P., 281, *289*
Gurin, G., 13, *28*, 411, 412, *450*
Gursslin, O. R., 186, 201, *212*

Haase, W., 19, *28*
Haggstrom, W., 172, *184*
Hallowitz, E., 83, *88*
Hanfmann, E., 406, *452*
Harper, E., 209, *213*
Harrington, C., 53, *60*
Harrington, M., 185, *212*
Harrison, S. I., 19, *28*
Harrower, M., 405, *453*
Hartmann, H., 47, 52, *60*
Hassol, L., 433, 435, 437, 441, *446*
Hastings, D. W., 57, *61*
Hauser, P., 57, *61*
Hawkinshire, F. B. W., 423, *450*
Haylett, C. H., 413, *450*
Hebb, D. O., 58, *61*
Helpern, J. M., 315, *329*
Hendrick, I., 47, *61*
Henry, G. W., 4, *29*, 69, 73
Hereford, C. F., 404, 422, *450*
Herma, J. L., 50, *60*
Heron, W., 58, *61*
Hersko, M., 185, *213*
Hetznecker, W., 196, 208, *212*
Hobbs, N., 11, 12, 22, *28*, *29*, 235, *236*, 411, 434, 444, *450*, *454*
Hoch, E. L., 433, 437, *450*
Hollingshead, A. B., 8, 19, *28*, 49, 57, *61*, 162, *184*, 185, 186, *212*
Hollister, W. G., 400, 405, *450*
Holzberg, J. D., 24, 92, 94, 98, 102, 104, *108*, *109*, 421, 422, 423, 424, 427, 429, *450*, *451*
Huang, I., 265, *269*
Hubbard, F. D., 423, *451*
Huessy, H. R., 414, 421, 422, 427, *451*
Hughes, H. S., 44, *61*
Hume, P. B., 437, *451*
Hunt, R. G., 185, 186, 201, *212*

Iker, H., 186, *212*
Imber, S. D., 185, *212*
Isaksen, H. L., 315, *329*
Iscoe, I., 9, 25, *28*, 315, 318, 323, *329*, *330*
Izzo, L. D., 14, 27, 208, *212*, 331, 332, 333, *351*, 405, 409, 422, *448*, *455*

Jackson, D. D., 71, *72*
Jahoda, M., 76, *87*, 164, *184*
Janis, I. L., 55, 57, *61*
Jarvis, P. E., 10, *28*
Jones, E., 44, *61*
Jones, M., 10, *28*, 130, *143*

Kanner, L., 352, *368*
Kanno, C. K., 35, *39*
Kantor, D., 100, *109*, 421, *450*, *451*
Kantor, M. B., 25, 296, 298, 299, *306*, 346, *351*

Kaplan, S. R., 171, 174, 178, *184*, 402, *453*
Kazanjian, V., 220, *236*, 413, *451*
Kelley, J. G., 401, 414, 415, *451*
Kenny, J., 132, *143*
Ketcham, W. A., 278, *289*
Kevin, D., 220, 221, *236*
Kiesler, F., 414, *451*
Kilpatrick, F. P., 57, *61*
Kipfer, J. F., 274, *289*
Klein, D. C., 55, 56, *61*, 83, 86, *87*, 404, 433, 435, 437, 441, *446*, *451*
Klein, H., 315, *329*
Klein, W. L., 24, 53, 144, 146, 147, 148, 149, 150, 153, 154, 156, 160, *161*, 403, 404, 421, 422, 423, 425, 426, 427, 429, 432, 433, *449*, *451*, *452*
Knapp, R. H., 24, 98, *109*, 421, 423, 424, 427, 429, *451*
Krueger, D. B., 19, *29*
Krugman, M., 404, *452*

Ladieu, G., 406, *452*
Laird, J. D., 348, *351*, 409, 422, 427, 429, *448*
Lambert, N. M., 404, 405, 408, *447*, *452*
Lamson, W. C., 235, *236*
Langner, T. S., 14, 19, *29*, 57, *61*, 128, *143*, 166, *184*, 186, *213*
Larson, C. A., 408, *447*
Lazarus, R. S., 407, *452*
Lebeaus, C. W., 199, *213*
Lecky, P., 55, *61*
Leighton, A. H., 14, 18, *28*, 172, *184*, 405, *452*
Leighton, D. C., 14, *28*
Lemkau, P. W., 19, *29*
Levine, M., 8, 9, 12, *29*, 153, 154, *161*, 402, 404, 405, 435, 437, *454*
Levine, R. A., 422, *452*
Levinson, D. J., 10, *28*, 398, *450*
Levitt, E. E., 17, *28*, 255, *269*, 408, *452*
Levy, J., 17, *27*
Lewin, K., 406, *452*
Lewis, N. D. C., 6, *28*
Lewis, W. W., 25, 353, *368*, 422, 423
Libo, L. M., 214, *236*, 414, *452*
Lindemann, E., 55, 56, 57, *61*, 405, *452*
Lippitt, P., 255, *269*
Lippitt, R., 255, *269*
Loftus, J. J., 253, *269*
Lowy, D. G., 92, *109*
Lucas, R. A., 55, 59
Lyle, W. H., 255, *269*

McCaffrey, I., 53, *61*
McCandless, B. R., 208, *212*
McDermott, J. F., 19, *28*
McGehearty, L., 25
MacLennan, B. W., 144, 146, 147, 148, 149, 150, 153, 154, 156, 160, *161*, 422, 423, *449*, *452*
McMahon, J. T., 185, *213*
McNeil, E. B., 275, 277, 279, *289*
Maddux, J. F., 221, 229, *236*
Madonia, A. J., 422, *455*
Magoon, T. M., 121, *127*, 437, *450*
Margolis, P. M., 437, *448*
May, E., 185, *213*
Mayer, A. J., 57, *61*
Mensh, I. N., 296, 299, 302, *305*, *306*
Merenda, J., 422, *455*
Meyerson, L., 406, *452*
Michael, D., 126, *127*
Michael, S. T., 14, 19, *29*, 57, *61*, 128, *143*, 166, *184*, 186, *213*
Miles, H. C., 14, *27*, 186, 195, 208, *211*, *212*, 331, 332, *351*, 405, 409, *448*
Miller, K., 315, *329*
Miller, S. M., 19, 20, *28*, *29*, 79, 82, *87*, *88*
Minuchin, P., 248, *251*
Mishler, E. G., 19, *28*
Mitchell, L., 144, 146, 148, 150, 156, 160, *161*, 422, 423, *449*
Mitchell, W. E., 421, *452*
Monck, E. M., 53, *61*

Moore, O. K., 47, 52, *59*
Morrison, A. P., 91, *109*, 421, 424, 427, *454*
Morse, W. C., 25, 272, 275, 278, 279, 281, 287, *289*
Murray, H. A., 47, *61*
Muuss, R. E., 255, *269*
Myers, J. K., 49, *61*, *62*, 185, 186, *211*, *213*
Myerson, A., 130, *143*

Nash, E. H., 185, *212*
Nelson, S. E., 10, *28*
Newman, R. G., 421, *453*
Nichols, R. S., 13, 14, *28*, 417, *452*
Nichtern, S., 371, 377, 379, *386*, 422, *449*
Norman, V. B., 233, *236*

Oberhauser, E. J., 423, *452*
Odoroff, C. L., 196, 208, *212*
Ojemann, R. H., 254, 255, 265, *269*, 285, *289*, 405, *452*
O'Neal, P., 409, 410, *453*
Opler, M. K., 14, 19, *29*, 128, *143*, 186, *213*
Orne, M. T., 442, *453*
Osgood, C. E., 346, *351*
Ozarin, L. D., 22, *29*

Padilla, E., 23, *29*
Palermo, D. S., 208, *212*
Parker, B., 221, *236*
Pasamanick, B., 19, *29*
Pearl, A., 17, 19, *29*, 144, 146, 147, 148, 150, 156, 160, *161*, 402, 422, 423, *449*, *452*, *453*
Peck, H. B., 83, *88*, 171, 174, 178, *184*, 402, 405, *453*
Pepper, M. P., 49, *61*
Perry, S. E., 55, *61*
Pierce-Jones, J., 25, 318, 323, *329*, *330*
Poser, E. G., 418, 419, 420, 421, 426, *453*

Queen, S., 209, *213*

Rae-Grant, Q. A. F., 403, *453*
Raines, G. N., 50, *62*
Rapoport, L., 413, *450*
Rappaport, J. D., 409, *448*
Raush, H. L., 149, *161*, 433, 437, *450*
Redl, F., 281, 284, *289*
Redlich, F. C., 8, 19, *28*, 49, *61*, 162, *184*, 185, 186, *212*
Reiff, R., 11, 24, 48, 49, 53, *62*, 74, 75, 78, 83, *88*, 171, 173, 176, *184*, 392, 402, 403, 420, 422, 423, 424, 426, 427, 428, 429, 430, 431, 432, 433, 440, *453*
Rein, M., 79, 86, *88*
Reinherz, H., 421, *453*
Rennie, T. A. C., 14, 19, *29*, 128, *143*, 186, *213*
Rice, D. L., 410, *455*
Rieman, D. W., 216, 221, *236*
Riessman, F., 17, 19, 20, 24, *29*, 48, 53, *62*, 77, 78, 83, *88*, 148, *161*, 165, 167, 172, 174, 176, *184*, 402, 422, 423, 424, 426, 427, 428, 429, 430, 431, *453*
Rioch, M. J., 24, 81, *88*, 113, *127*, 419, 421, 422, 423, 424, 425, 426, 427, 428, 429, 431, 440, *453*
Roach, J. L., 186, 201, *212*
Robbins, L. N., 409, 410, *453*
Roberts, D. W., 19, *29*
Robinson, R., 414, *453*
Rockefeller, W., 422, *453*
Roen, S. R., 25, 258, 260, 261, 263, 266, *269*
Rohrer, J. H., 50, *62*
Roman, M., 171, 174, 178, *184*, 402, *453*
Romano, J., 9, 24, 34, 39, 186, 195, *211*, *212*, 443
Rosen, B. M., 233, *236*
Rosenbaum, M., 85, *88*, 427, *454*
Rosenblum, G., 315, *329*, 433, 435, 437, 441, *446*
Rosenthal, D., 49, *62*
Rosenthal, R., 442, *454*
Rosenthal, S., 257, *269*
Rosenzweig, S., 17, *29*

Ross, A. O., 433, *450*
Rudolph, C., 53, *61*

Sabshin, M., 438, *454*
Sanders, D., 9, 11, 22, *27*, 397, 411, *449*
Sanders, R., 24, 132, *143*, 421, 423, 424, 425, 431, 432
Sanford, N., 8, 9, 18, 22, 24, *29*, 399, 405, *454*
Sanua, V. D., 13, 19, *29*, 68, 73
Sarason, S. B., 8, 9, 12, *29*, 402, 404, 405, 435, 437, *454*
Schaffer, L., 9, *62*, 185, 186, *213*
Scheff, T. J., 42, *62*
Schilder, P., 47, *62*
Schneiderman, L., 20, *29*
Schofield, W., 6, 12, 13, 17, *29*, 395, 412, *454*
Schorr, A. L., 185, 197, 199, *213*
Schrager, J., 9, *28*
Schwitzgebel, R. R., 423, *454*
Scott, W. A., 49, *62*
Scribner, S., 74, *88*
Seeley, J. R., 253, *269*
Selesnick, S. T., 3, *26*
Sexton, P., 172, 174, *184*
Sheeley, W. F., 415, *454*
Shellhamer, T. A., 410, *447*
Sherwood, C. C., 443, 444, *449*
Shoben, E. J., 299, *306*
Silber, E., 55, *61*, 421, *453*
Silberman, C., 172, *184*
Simmons, O. G., 40, 53, *60*
Slack, C. W., 423, *454*
Slavson, S., 291, *306*
Smith, A., 132, *143*
Smith, M. B., 11, 22, *29*, 235, *236*, 411, 444, *454*
Smith, R., 132, *143*
Snider, B., 255, *269*
Spano, B. J., 264, *269*
Spiegal, A. D., 405, *454*
Spielberger, C. D., 24, 217, 218, 221, 235, 413, 414
Srole, L., 14, 19, *29*, 128, *143*, 186, *213*, 437, *454*
Star, S., 75, *88*
Stein, S., 220, *236*, 413, *451*
Steiner, G. A., 266, *268*
Stennett, R. G., 409, *454*
Stiles, F. S., 254, 255, *270*
Stone, A. R., 185, *212*
Storrow, H. A., 49, *60*, 186, *212*
Straetz, R., 23, *29*
Strom, R. D., 404, *454*
Stubbs, T. H., 233, *236*
Suci, G. J., 346, *351*
Sutton-Smith, B., 281, *289*
Sweet, B., 149, *161*
Szasz, T., 41, *62*, 77, *88*, 352, *368*

Taba, H., 253, *270*
Tannenbaum, P. H., 346, *351*
Tashnovian, P. J., 408, *447*
Telschow, E. F., 14, *27*, 208, *212*, 331, 332, *351*, 405, 409, *448*
Thorpe, L. P., 265, *270*
Tiegs, E. W., 265, *270*
Tienari, P., 71, 73
Topping, G. G., 53, *60*
Torrance, E. P., 321, *330*, 404, *454*
Trost, M. A., 14, *27*, 208, *212*, 331, 332, 333, *351*, 405, 409, 422, *448*, *455*
Turner, J. L., 24, 423, 424, 429
Turner, R. J., 24, 55, *62*, 196, 208, *212*
Tyhurst, J. S., 57, *62*

Uihlein, A., 421, *448*
Umbarger, C. C., 91, *109*, 421, 424, 427, *454*
Usdansky, B. S., 421, *453*

Veroff, J., 13, *28*, 411, 412, *450*
Volkman, R., 428, *454*

Wagle, M. K., 414, *453*
Walker, W., 144, 146, 147, 148, 150, 153, 154, 156, 160, *161*, 422, 423, *449*
Warner, A., 209, *213*
Weinberg, W. L., 220, *236*, 413, *451*
Weinman, B., 132, *143*
Wertheimer, M., 17, *27*

Westby-Gibson, D., 404, *455*
Westman, J. C., 410, *455*
White, R. W., 47, 52, 56, *62*
Whitehead, A. N., 43, *62*
Whiteside, M. F., 255, *269*
Whiting, H. S., 92, *109*
Wilensky, H. Z., 199, *213*
Wilkins, M. L., 53, *60*
Williams, R. H., 10, 18, 29, 397, 398, *455*
Wilson, P., 19, *28*
Wilson, R. N., 55, *62*
Wiltse, K. T., 199, *213*
Winder, A. E., 185, *213*
Winder, C. L., 433, *450*
Winsor, C., 254, *268*
Wolf, D., 315, *329*
Wolpin, M., 421, *449*
Wood, H., 265, *270*
Wright, B. A., 406, *455*
Wright, H. F., 363, *368*
Wurm, C., 437, *450*

Yablonsky, L., 428, *455*
York, R. H., 130, *143*

Zax, M., 14, 25, 27, 208, *212*, 331, 332, 348, *351*, 405, 409, 421, 422, 423, 424, 425, 427, 429, *448*, *451*, *455*
Zilboorg, G., 4, 29, 69, 73
Zimiles, H., 25, 254
Zwerling, I., 36, 37, 39, 85, *88*

SUBJECT INDEX

Acceptance, school and, 241
Activity skills, training in, 134-135
Activity Therapies Department, 139
Adolescents, housewives as therapists for, 114
After-school preventive program, 341 ff.
Aggressive behavior, moral judgment of, 104
Aid to Dependent Children, 199n.
Aides
  community action, 422-423
  housing service, 422
  human service, training of, 144 ff.
  range of skills for, 182
  teacher, 336 ff.
Alcoholism, 193
American Orthopsychiatric Association, 291
American Psychiatric Association, 384
Anxiety
  Companion program and, 104-105, 106
  consultant trainees and, 316
Apathetic poor, 173
Attendants, hospital, 129
Attitude scale for mothers, 299 ff.
Austin Independent School District, 311, 312
Autobiographical Data, 319

Bank Street College, 242 ff., 253, 255
Behavior Classification Checklist, 319
Behavior Preference Record, 265
Behavioral sciences in schools, 257 ff.
  evaluating effectiveness of, 264-266
  further implementation of, 267-268
  residential setting and, 263-264
Benjamin Rush Clinic, 181
Biological explanation of behavior, 4
Biological research, 69

California Test of Personality, 265
Care-givers, 411 ff. *See also* Nonprofessionals; Professionals.
Case-seminar method, 217 ff., 225 ff.
Caseworkers, welfare, 229
Causal learning, 255, 256, 265, 266
Centralization of administration, 209-210
Children
  adjustment level of, 296
  behavior consultants, training of, 314 ff.
  characteristics of consulted, 324-325
  early identification in, 332 ff.
  early intervention in, 407 ff.
  emotionally disturbed
    teacher-counselors for, 352 ff.
    teacher-moms for, 369 ff.
  housewives' counseling of, 115, 122 ff.
  life space theory and, 281-282, 284-285
  primary prevention in classroom for, 252 ff.
  psychological influence of school on, 239 ff.
  situational analysis of, 282-283
  teenagers in care centers for, 145
Children's Anti-democratic Scale, 255
Children's Picture Story Test, 246, 248
Chronically ill
  effectiveness of professional vs. nonprofessional therapy for, 418-419, 426
  socioenvironmental therapy for, 130 ff.
  undergraduates as Companions to, 91 ff.
Civil rights movement, 10
Clinical management of education, 275 ff.
Clinical psychiatry, 85
Closed-system orientation, 44-46
Cognitive development, school and, 245, 250, 254, 259
Cohesion, social, 165-166, 173
College graduates as therapists, 128 ff.

College students
  in after-school preventive program, 341 ff.
  changes in teaching of, 33-34
  as companions to chronically ill, 91 ff.
  effectiveness of, as therapists, 418-419, 426-428
  selection of, 424
Columbia-Washington Heights Project, 196
Community Mental Health Act, 11, 22
Community mental health programs, 37
  community action, 83, 171 ff.
  consultation with community leaders, 235
  evaluation of, 105-106, 137-138, 221, 264-266
  guidelines for, 49, 58, 374
  interagency organization in, 235
  models of, 91, 92, 113, 115, 129, 130, 144-145, 148, 163, 174 ff., 215, 222, 244, 260, 271 ff., 291, 308, 331-332, 336-337, 341, 353-354, 374
  problems with, 140-142
  success criteria for, 49
Community psychiatry, 37-38, 79-80, 110, 126, 401
  criticisms of, 38, 79, 81
  mental health team and, 196 ff., 209
  programs in, 69
Companion program with undergraduates, 91 ff.
  activities in, 95-96
  characteristics of students in, 98-99
  effects on patients, 99-101
  effects on students, 101 ff.
Compensating devices, 45 ff.
Competence, 47
Comprehensive Community Mental Health Centers, 64
Comprehensiveness of programs, 80
Conceptualization, 391-392
Conceptualizer-participant, 82, 441
Conflict, stimulation of, 172
Congress, 67
Constituency, political clout and, 86
Consultant Report Form, 320
Consultation, 214 ff.
  assessment techniques in, 318 ff.
  case-seminar method in, 217 ff., 225 ff.
  child behavior, 314 ff.
  community orientation in, 232-234
  by graduate students for teachers, 307 ff.
  locus and time for, 317
  ministers and, 227-228
  primary prevention and, 234-235
  principles of, 216-217
  professional and, 218, 225 ff., 234, 314, 317, 357, 358, 360, 361, 413-415
  public health nurses and, 225-227
  public schools and, 229-232
  targets of, 221, 223-224, 235, 315
  teachers and, 274 ff.
  training in, 232, 314 ff.
  utilization of, 223
  welfare caseworkers and, 229
  Wilmington program, 222 ff.
Core concepts
  for human service aides, 149 ff.
  in school mental health program, 272 ff.
Counseling
  housewives, 110 ff.
  Neighborhood Service Center, 168
  pastoral, 228
  teacher, for emotionally disturbed, 352 ff.
  See also Consultation
Crime, children's opinions on, 247
Crises
  disequilibria of, 57
  intervention, 215, 305-307
  resolution, 54-56
  teacher, 287
Cumberland House Elementary School, 353
Curriculum
  content, use of, for mental hygiene, 285
  improvement, 253-254

Day-care centers
  housewives counseling in, 115, 122 ff.
  prevention in, 341 ff.
  teenagers for, 145
Decision-making by delinquent trainees, 152 ff.
Delinquents, training of, 145 ff.
Demand
  "effective," 171
  for mental health services, 12 ff., 20
Dimensions of Teachers Opinions, 319
Discontinuity of care, 197
Disease model, 69 ff., 393
Disequilibria of crises, 57
Disequilibrium, progressive, 47
Doctoral training, 437
Dramatization for learning, 245
Dropouts, training of, 145 ff.
Drug therapy, 40, 79

Economic Opportunity Act, 171
Economics of Freudian theory, 44-45
Education
  clinical management of, 275 ff.
  ideology, traditional vs. modern, 243, 246
  level of, of housewife counselors, 118, 126
  nonintellective, 103, 108
  See also Training
Effectance motivation, 47
Ego psychology, 45, 52-53, 54
  identity and, 55, 58
  poor and, 181-182
  school and, 245, 254, 258-259
  teachers and, 277
Elementary school
  behavioral sciences in, 257 ff.
  counselors, 230
Emergency services, 38, 181
Emotional adjustment of children, 296 ff.
Emotionally disturbed children
  early intervention for, 407 ff.
  teacher-counselor for, 352 ff.
  teacher-moms for, 369 ff.
Environment
  influence of, 47, 54, 56 ff.
  therapeutic community and, 129 ff.
Ethical choice, 223, 224
Etiology of emotional disorder, 395

Father-son role, 364
Federal Community Health Program, 86
"Fee for service" ethic, 78
Finances, 14-15, 35, 416
Florida, University of, 264
Fourth-grade behavioral sciences, 257 ff.
Fragmentation of care, 198-199, 386

Graduate students
  ratings of day-care program, 346
  as teacher consultants, 307 ff.
Group Leader Evaluation Inventory, 137-138
Group sessions, 130 ff., 217 ff.
  counselor trainees for, 116, 117
  day-care activity program, 344-345
  effectiveness of professional vs. nonprofessional in, 418-419, 426-428
  human service aide training in, 150 ff.
  vs. individual consultation, 234-235
  Neighborhood Service Center and, 176-177
  for parents, 290 ff.
  teacher's role in mental health and, 276
Grouping, school, 373
Guidance counselors, 230, 231

Habit formation, 266
Hampshire County School, 263
Harlem, 172, 257
Health Department services, 200, 215, 222, 293
Hearing and speech service, 371
Helper-therapy principle, 429
Heredity, 71
High school counselors, 230, 231

Hill-Burton Hospital Law, 35
Home vs. school influence, 244
Homemaker, 422
Hospital
  college students as Companions in, 91 ff.
  psychiatric units, 35, 64
  state, history of, 129
Hospitality index, 273
Housewives
  as counselors, training of, 110 ff.
  selection of, 424
  as teacher aides, 336 ff.
  as teacher-moms, 375 ff.
Housing service aide, 422
Human growth and development instruction, 157
Human service aides, training of, 144 ff.

Inadequacy syndrome, 53
Individual
  vs. group consultation, 234-235
  integration of social process with, 82
Industrial model, 80-81, 420
Inequities in services, 19-20
Inertia, intellectual, 439
Innovation, training for, 440-441
Institute of Social Research, 255
Institute for Youth Studies, 145, 152
Institutional change, 166, 177 ff.
Institutional roadblocks to teachers, 285-286
Institutions, 5
  change in, 74 ff.
  See also Hospitals
Insurance programs, 35, 38, 64, 65
Intergroup programs, 177
Interviewing by housewives, 119-120
Introspectiveness, Companion program and, 104-105
"Involvement-enthusiasm" hypothesis, 427

Job descriptions, 157-158
Joint Commission on Mental Illness and Health, 9-11, 13, 21-22, 49, 67, 102, 233, 257, 408, 444

Leaders of community, consultation with, 235
Legislation, 22, 65, 67
Level-of-organization disorders, 42-43
Liaison teacher in Re-ED, 360-361
Libido-quantum theory, 45, 52
Life space theory, 281-282, 284-285
Lincoln Hospital Mental Health Services, 163, 164, 175
Local issues, involvement in, 172
Local responsibility, 37
Low-income people, see Poor

Manhattan survey, 19, 128
Manpower problem
  causes of, 128-129
  conceptual models and, 63 ff.
  existing, 14-15
  institutional change and, 74 ff.
  needs, 12 ff., 63, 72, 80, 110, 128, 214, 232-233, 353, 396, 417
  reconceptualization of, 68
  training problems, 140-142
Maternal assessment of child's adjustment, 296 ff.
Maternal attitude scales, 299 ff.
Medical model, 41 ff., 392 ff.
  academic psychologist and, 46
  assumptions of, 352, 391, 395, 396
  changes in, 64 ff., 398
  compensatory vs. open, 47-48
  conceptual problems with, 49-51, 397
  criticisms of, 41-43, 49, 53, 64, 394 ff.
  disease model, 69 ff., 393
  historical antecedents of, 43 ff., 394, 399
  individual therapy and, 41
  mental health problems and, 41-42, 48 ff., 393-394
  nonprofessional role in, 420, 421
  principles of, 42, 393
  tools of, 42
Medical services of school, 371

Medicare, 65
Medicine
  educational changes and, 34-35
  role of, 200
Mental health, definition of, 42
Mental Health Analysis, 265
Mental health institutions, history of, 33-34
Mental health movement, 33 ff.
  causes of, 40, 201
  conceptualization in, 391-392
  Community Mental Health Act and, 11, 22
  current perspectives in, 11-12
  demand and need in, 12 ff., 20, 78-79
  historical perspective of, 1 ff.
  inequities in, 19-20
  Joint Commission on Mental Illness and Health and, 9-11, 13, 21-22, 49, 67, 102, 233, 257, 408, 444
  National Committee for Mental Hygiene and, 7
  National Mental Health Act and, 9, 35
  objectives of, 36
  Office of Economic Opportunity and, 10-11, 164
  prevention and, 7
  psychiatry and, 35 ff.
  school as focus in, 278 ff., 404-405
  team in, 196 ff.
Mental illness, 74
  attitudes toward, 101-102
  incidence of, 214
Michigan Society for Mental Health, 271, 273
Middle class
  adjustment of children of, 298 ff.
  housewives as therapists for, 115
Midtown Manhattan Survey, 19, 128
Milieu therapy, 129 ff.
Million dollars dilemma, 246-247
Ministers, case-seminar with, 227-228
Minnesota Multiphasic Personality Inventory, 100, 104
Mobilization for Youth, 168, 174, 179
Moral judgment, Companion Program and, 103-104
"Moral weakness," 77
Mothers
  assessment of child's adjustment, 299 ff.
  in poverty, 71
  unwed, 199
Motivation
  for delinquents, 147
  effectance, 47
  role prescription and, 367
  for student Companions, 99
Multi-agency involvement, 197-198, 386

National Committee for Mental Hygiene, 7
National Institute of Mental Health, 35, 113 ff., 133, 295, 333
National Mental Health Act, 9, 35
Naturalism, 44
Need for Assistance Scale, 319
Needs for mental health services, 12 ff., 20, 148
Neighborhood Service Center, 83, 162 ff., 403
  community action model, 165-166, 171 ff.
  costs of, 183
  functions of, 166 ff.
  goals of, 165-166, 180 ff.
  institutional change and, 177 ff.
  nonprofessionals in, 167, 168, 170, 173, 174-175, 181, 182
  past failures of, 169-171
  prevention, 164, 166 ff., 180 ff.
  structure of, 164
Neurosis, popular vs. professional view, of, 76
New Hanover County Association for Mental Health, 215
Newtonian physics, 44-45
New workers and techniques, resistance to, 141
New York City schools, 253, 257
Nonintellective education, 103, 108
Nonprofessionals, 15, 417 ff.
  assets of, 426 ff.

Nonprofessionals (*cont'd*)
  changes in, 429-430
  college student as, 91 ff., 341 ff., 424
  employment of, 121, 138-140
  evaluation of, 120-121, 126-127, 418-419, 426-428
  housewives as, 110 ff., 336 ff., 375 ff., 424
  judicious use of, 434-435
  medical model and, 48
  in neighborhood community action, 83-84, 167, 168, 170, 174-175
  positive personal changes in, 430
  problems of, 430 ff.
  roles and functions of, 420 ff.
  selection of, 116-117, 132-133, 136, 144-146, 174-175, 337, 342-343, 375, 423-424
  struggle of, vs. professional, 86
  teenager as, 244 ff.
  training of, 424-426, 432. *See also* Training
Northeast Independent School System, 311, 312
Nurses, case-seminar with, 225-227

Occupational inadequacy, 53
Office of Economic Opportunity, 10-11, 164
On-the-job experience for human service aides, 155 ff.
Openness, 56-57, 58
Open-system orientation, 46-47
Opinions about Mental Illness (OMI), 103
Order, attempts at, 43-44
Otis Group Intelligence Test, 230
Outpatient care, 195, 201

Paramedical group interest, 38
Parents
  attitude scales, 299 ff.
  early detection and, 332, 335-336
  emotional adjustment of children and, 296 ff.
  group therapy in schools and, 290 ff.
  teachers' meetings with, 276-277
Participant-conceptualizers, 82, 441
Passivity, 173
Pastoral counseling, 228
Pathology
  in children consulted, 325
  educational intervention and, 356
  medical model and, 393
  rates, 50-51, 172
Patients
  Companions for chronically ill, 91 ff.
  government of, 131-132, 135
  professional vs. nonprofessional therapy for, 418-419, 426
  socioenvironmental therapy for, 130 ff.
Paying
  human service aides, 152
  Neighborhood Service Center workers, 183
People-centered operations, 405
Personality development, 45 ff.
  closed systems and, 44-46
  compensation and, 45
  open systems and, 46-47
  theory training, 134
Philadelphia State Hospital, 130
Physics, influence of, 44-45
Physiological dysfunction, 52
Planning, 37, 222-223
Play, 245, 344
Political clout, 86
Poor
  adjustment of children of, 298 ff.
  alienation of, 123, 185, 196-197, 402
  apathetic, 173
  communication problems with, 48-49, 75, 162
  ideological focus of, 77
  mental health services for, 74-75, 191 ff.
  mental illness in, 19, 57, 188 ff.
  mothers, 71
  multi-agency involvement of, 197-198
  neighborhood center for, 162 ff.
  reorganization in psychiatry for, 209-210

Poor (*cont'd*)
  research techniques for, 186 ff.
  self-determination vs. self-actualization in, 77
Postdoctoral training, 436-437
Power issues, 84-85
Preciousness, 435
Prevention, 18-19, 21, 398 ff.
  consultation and, 216
  crisis theory and, 405-407
  criticisms of, 408, 415-417
  early detection and, 331 ff., 400, 407 ff.
  function of, 81, 401
  habitats for, 403-404
  interdisciplinary struggles in, 83 ff.
  neighborhood centers and, 166 ff.
  nonprofessional role in, 405, 411 ff., 422
  people-centered operations, 399 ff.
  poor and, 402-403
  primary, 18, 81-82, 240, 252 ff., 400, 407
  professional role in, 413, 414
  in schools, 230-240, 250, 252 ff., 331 ff., 375 ff., 400, 404, 407
  secondary, 18, 180-182, 400, 405, 407, 411
    after-school program and, 341 ff.
    traditional methods and, 353
  social systems change and, 399
  systems-centered operations, 399 ff.
  target groups for, 341, 403-404
  tertiary, 18, 180-182, 400
  theoretical basis of, 399 ff.
  usefulness of, 408-410
Private care vs. public care, 63
Problem resolution, 54-56
Problem Situation Test, 255
Professionals, 14-15, 433 ff.
  changing role of, 15-16, 40, 82 ff., 154, 400-401, 433-434
  for Companion program, 93-94
  in consultation, 218, 225 ff., 234, 413-415
  effectiveness of, vs. nonprofessional, 418-419, 426-428
  inequities in services and, 20
  institutional change and, 74 ff.
  judicious use of nonprofessionals by, 434-435
  misrepresentation as, 141-142
  for parental group therapy, 291
  poor and, 76
  vs. popular view of mental health, 75-76
  preciousness of, 435
  resistance to change of, 141, 431-432, 439-440
  responsibility of, 390-391
  role of, vs. nonprofessional, 420-421
  supply of, 36, 66, 80
  teacher-counselors and, 357, 358, 360, 361
  teacher-moms and, 379
  training of, 436 ff.
Protest social action group, 179
Psychiatric ratings, 50
Psychiatrists, number of, 36, 66
Psychiatry, 85
  clinics, 35, 64, 201, 401
  cross-sectional patterns of, 191-192
  dissatisfaction with current, 40-41
  longitudinal patterns of, 192 ff.
Psychoanalysis, 36, 85, 253
Psychological influence of school, 239 ff., 274-275
Psychology
  clinical, 85-86
  mental health worker and, 139-140
  school services in, 371, 385
  study of, in America, 35-36
  theology conflicts with, 228
  training in, 437
Psychosis, 76, 194, 195
Psychotherapy
  aims of, 77, 78
  alternatives to, 18-19
  educative process as, 385
  hopes for, 16-17
  housewives and, 114 ff.
  reinforcement in learning about, 317
  teacher counselors for, 352 ff.
Psychotropic drugs, 40
Public care vs. private care, 63 ff.

Public health nurses, case-seminar with, 225-227

Reading teachers, 372
Re-ED, 352 ff.
Referrals
  to mental health teams, 202
  for schools, 287-288
  teacher aides and, 340
  teacher-counselors and, 355
Rehabilitation, neighborhood centers and, 182
Religion, counseling and, 228
Remotivation program, 96n.
  for characteristics of successful mental health workers, 138
  for college graduate capability, 137
  historical role of, 441-442
  for hospitals, 142
  Joint Commission Report and, 444
  for schools, 248 ff., 319, 347 ff.
Resources, existing, 14-15
"Risk category" rating, 144
Role theory, 363 ff., 367

St. Louis project, 290 ff.
Schizophrenia, 194, 196
  case vignettes of, 380-381
  group therapy for, 418-419, 426
  teacher-moms for, 369 ff.
School
  Bank Street College study, 242 ff.
  behavioral sciences in, 257 ff.
  cognitive development and, 245, 250, 254, 259
  comfort in, 259
  as competent institution, 309-311
  consultation in, 229 ff.
  core concepts and, 272 ff.
  curriculum, 254 ff., 285
  emotional investment in, 240-241
  future research for, 248 ff.
  health services in, 370 ff.
  home influence vs., 244
  mental health program, 278 ff.
  parent group therapy in, 290 ff.
  prevention in, 239-240, 250, 252 ff., 331 ff., 375 ff., 400, 404, 407
  psychological influence of, 239 ff., 274-275
  psychological services in, 371, 385
  referral processes, 287-288
  self-perception and, 245
  sex differences in influence of, 247-248, 250
  social worker, 335-336
  teacher aides in, 336 ff.
  teacher mental health role in, 271 ff., 354 ff.
  teacher-moms in, 375 ff.
  technological change and, 309
  total atmosphere emphasis in, 253-254
  traditional vs. modern ideology, 243, 246
Secondary prevention, *see* Prevention, secondary
Self-acceptance, Companion Program and, 103-104
Self-actualization, 77
Self-analysis by teachers, 283-284
Self-concept, life space theory and, 281-282
Self-critical programming, 158-159
Self-definition, 58
Self-perception, school and, 245
Seminar
  behavioral sciences, 266-267
  case, 217 ff., 225 ff.
  mental health role and, 276
Sex differences in school influences, 247-248
Sexual behavior, moral judgment of, 104
Short-term services, 38
Situational analysis by teachers, 282-283
Skills, learning of
  in Re-ED, 356-357
  by teachers, 284-285
Slow learners, 266-267
Social action, definition of, 171
Social cohesion, 165-166, 173
Social institutions training, 134
Social learning theory, 70-71

Social movement in mental health, 33 ff.
Social organizations, milieu therapy and, 131
Social sciences
  in elementary school, 257 ff.
  study of, in America, 35-36
Social systems change, 81-82
  goals, 177-178, 362-363
  operant learning and, 367
  prevention and, 180
  role theory and, 363 ff.
  school and, 288, 362 ff.
Social work
  political clout of, 86
  Re-ED and, 360
  volunteers vs. mental illness volunteers, 102-103
Society for the Prevention of Cruelty to Children, 200
Socioeconomic class
  adjustment of children and, 298 ff.
  behavioral sciences and, 264-265
  housewives as therapists and, 115, 123
  incidence of disorders and, 186, 191
  inequities in services for, 19, 75, 402
  symptomatology level and, 57
Socioenvironmental therapy, 129 ff.
  history of, 130
  training in, 134 ff.
Sociometrics, *see* Testing
South Shore Mental Health Center, 257, 263
Specialized skill instruction, 154-155
Speech service, 371
Staff meetings, socioenvironmental therapy and, 131
State hospital
  attendants, 129
  history of, 129
Street argument, 149
Stressors, 57
Style and skill expansion, 163
Style match approach, 162, 402, 429
Subprofessional workers, 140-142
Suggestibility, 57
Suicide, 172
Surgeon General's Ad Hoc Committee, 233, 234
Symptomatology, 49-50, 53
  Companion program and, 100
  maternal assessment of, 297-299
  in poor, high level of, 57
Systems-centered operations, 399 ff.

Talking, Companion and patient, 95
Tattling, 266
Task-oriented groups, 177
Teacher-moms, 375 ff.
Teachers
  behavioral science, 255, 256, 266-267
  conceptual material and, 286-287
  consultations, 230, 274 ff., 307 ff., 353 ff.
  crisis, 287
  early detection and, 332
  ego strength development of, 277
  institutional roadblocks to, 285-286
  itinerant, 372
  liaison, 360-361
  mental health functions of, 271 ff.
  reading, 372
  referral processes and, 287-288
  self-analysis by, 283-284
  situational analysis by, 282-283
  special skills for, learning of, 284-285
  special subject, 372-373
  strain relief for, 280-282
  visiting, 372
Team, mental health, 196 ff.
  duties of, 334-336
  evaluation of, 207-208
Technology
  influence of, 308-309
  medical model and, 396
Teenagers, training of, 144 ff.
Tension-releasing models, 46
Tertiary prevention, 18, 180-182, 400
Testing
  behavioral science, 260, 265
  of Companions, 98, 100
  early detection and, 335
  emotional adjustment and, 299

Testing (*cont'd*)
  of graduates, 138, 318 ff.
  for maternal attitudes, 299 ff.
  nonprofessional for, 420-421
  school influence and, 246
Theology, psychology conflicts with, 228
Therapeutic community, 130 ff.
Therapeutic intervention, 55
Therapeutic social club, 130
Therapy, *see* Psychotherapy
Torrance Scale, 321-322
"Total push" treatment, 130
Training
  abstractness of, 425
  behavioral science, 255, 256, 266-267
  changes, in universities, 33 ff.
  child behavior consultant, 314 ff.
  Companions, student, 94
  consultants, 232
  counselors, 110 ff.
  human service aides, 144 ff.
  innovation and versatility, 440
  neighborhood centers, 174-175
  new personnel, 140-142
  nonprofessional, 424-425, 432
  professional, 436 ff.
  socioenvironmental therapy, 133 ff.
  teacher aides, 337-338
  teacher-counselors, 353-354, 357-359
  teacher-moms, 376
  transfer of, in first grade, 266
Tuberculosis, 308

Undergraduates, *see* College students
Unions, 67
University changes, 33 ff.
Unmet needs of society, 148
Unwed mothers, 199
Urban agents, 414

Verbal contagion, 149
Versatility, training for, 440-441
Visits, Companions for, 95, 96
Vocational interest
  behavioral sciences and, 260
  Companion program and, 107
  socioenvironmental therapy and, 138-140
Volunteers
  characteristics of students as, 98-99
  Companion, 91 ff.
  housewife, 116
  See also Nonprofessionals
Vulnerability, 56-57

Walk-in clinic, 79-80
Welfare organizations
  caseworkers, seminars with, 229
  history of, 199-200
Well-baby clinics, housewives counseling, 115, 122 ff.
Wilmington program, 222 ff.
Woodlawn Organization, 172
World Wars, impact of, 8-9, 36, 37
Wright School, 353